Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 11, 2025

Licensee
A To Z Group Homes Limited
1067 12th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL37814016

Dear Licensee:

On July 18, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 1, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 1, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 1, 2025, found not corrected at the time of the July 18, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0680 - Disaster Planning And Emergency Preparedness - 144g.42 Subd. 10 - $500.00
1370 - Training And Evaluation Of Unlicensed Personnel - 144g.61 Subd. 2 (a) - $500.00
1380 - Training And Evaluation Of Unlicensed Personnel- 144g.61 Subd. 2 (b) - $500.00

The details of the violations noted at the time of this follow-up survey completed on July 18, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on July 18, 2025, we identified the following violation(s):

0340 - Correction Orders - 144g.30 Subd. 5 - $500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

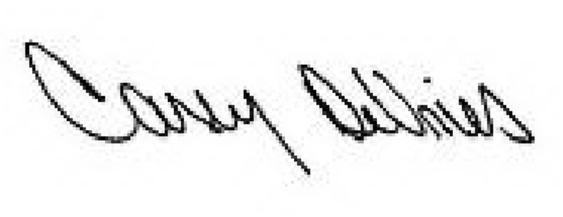
To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37814	A. BUILDING: _____ B. WING _____	R 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TO Z GROUP HOMES LIMITED	1067 12TH AVENUE SE MINNEAPOLIS, MN 55414

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37814016-1 On July 14, 2025, through July 18, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 1, 2025. At the time of the survey, there were four residents; three receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/ or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and 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 the correction orders for a survey completed on May 1, 2025. 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	0 340		

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0 340	Continued From page 2 of the residents). The findings include: On July 14, 2025, at 7:41 a.m., the surveyor requested documentation of actions taken to comply with citations. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they would have a staff member at the facility find the documentation. On July 14, 2025, at 8:04 a.m., the surveyor received a document titled, "[licensee] Action Plan for Survey Results, May 1, 2025". On page two of the document, in the column titled "tag" was the number "0680". In the column titled, "Action plan/Time Frame/Responsible Person" there was the following statement, "1 purchase updated emergency plan (EP) template manual, 2 having consultant assist in completing of agency-specific content". On page three of the document, in the column titled "tag" were the numbers "1370 and 1380". In the column titled, "Action plan/Time Frame/Responsible Person" there was the following statement for both 1370 and 1380, "1 develop a template of required topics, 2 update Educare courses to reflect what the agency needs, 3 RN [registered nurse] to complete requirements for the staff". On July 14, 2025, at 10:39 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were working with a consultant company to correct the citations issued from the survey completed on May 1, 2025, by the Minnesota Department of Health. CNS/LALD-C stated they had not received guidance from the consultant company and not had started to correct those particular citations. CNS/LALD-C stated they were aware of the	0 340		

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0 340	Continued From page 3 required timeframes to correct. On July 18, 2025, the follow-up survey concluded, and the following correction orders were re-issued: 0680, 1370, 1380. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{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:	{0 480}	Not reviewed during this survey.	
{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	{0 680}		

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{0 680}	Continued From page 5 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 interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan 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).	{0 680}		

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{0 680}	Continued From page 6 The findings include: The licensee's undated EP plan, lacked evidence of the following required content: - annual review; -risk assessment should consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - risk assessment of various probably risks/hazards by likelihood of occurrence; - risk assessment of interruption of services and consider emerging infectious diseases; - population needs: independence, communication, transportation, supervision and medical care; - identify staff specific roles in another's absence through succession planning and delegation of authority; - developing and implemented EP policies/procedures based on the emergency plan, risk assessment and communication plan: addressing evacuated or shelter in place for staff and residents: food, water, medical supplies, pharmaceutical supplies, temperatures to protect resident health/safety, safe/sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems and sewage and waste disposal; - developing a plan for safe evacuation from the facility, including consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - policies and procedures for medication documentation; - arrangements with other facilities/providers,	{0 680}		

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{0 680}	Continued From page 7 including signed agreements; - roles under a waiver declared by secretary; - names and contact information for entities providing services under agreement, residents' physicians, other facilities, volunteers; - emergency officials contact information for Federal, State, Tribal, regional and local EP staff, State licensing and certification agency, Minnesota Office of Ombudsman for long-term care; - methods for sharing information; - sharing information on occupancy/needs; - long-term care (LTC) family notifications, and; - emergency prep training program. On July 15, 2025, at 9:25 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they hired an assisted living consultant company after the previous survey completed on May 1, 2025, by the Minnesota Department of Health. CNS/LALD-C stated they had not received any input or updates from the consultant company to correct the required information for the EP plan. CNS/LALD-C stated they were aware of the required timeframes to correct the citation. The licensee's undated Emergency Preparedness policy indicated licensee would have an identified 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.	{0 680}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 8 (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}	Not reviewed during this survey.	

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{01370}	Continued From page 9	{01370}		
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	{01370}		

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{01370}	Continued From page 10 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services, for two of three unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired October 24, 2024, to provide direct care services. ULP-A's employee record lacked evidence of the following: Trainings: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider, and; - awareness of commonly used health technology equipment and assistive devices. Competency evaluations: - standby assistance techniques and how to	{01370}		

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{01370}	Continued From page 11 perform them. ULP-B ULP-B was hired on December 14, 2024, to provide direct care services. ULP-B's employee record lacked evidence of training for the following: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family, and; - awareness of commonly used health technology equipment and assistive devices. On July 14, 2025, at 10:39 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were working with a consultant company to correct the citations issued from the survey completed on May 1, 2025, by the Minnesota Department of Health. CNS/LALD-C stated they had not received guidance from the consultant company and not had started to correct the citation. CNS/LALD-C stated they were aware of the required timeframes to correct the citation. The licensee's undated Staff Competency Evaluation policy indicated licensee would ensure staff would complete trainings in the areas listed above. No further information was provided.	{01370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37814	A. BUILDING: _____ B. WING _____	R 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01380}	Continued From page 12	{01380}		
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services, for two of three unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{01380}		

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{01380}	Continued From page 13 The findings include: ULP-A ULP-A was hired October 24, 2024, to provide direct care services. ULP-A's employee record lacked evidence of training for the following: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; - recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-B ULP-B was hired on April 12, 2025, to provide direct care services. ULP-B's employee record lacked evidence of training for the following: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; - recognizing physical, emotional, cognitive, and developmental needs of the resident. On July 14, 2025, at 10:39 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were working with a consultant company to correct the citations issued from the survey completed on May 1, 2025, by the Minnesota Department of Health. CNS/LALD-C stated they had not received guidance from the consultant company and not had started to correct the citation. CNS/LALD-C stated they were aware of the required timeframes to correct the citation.	{01380}		

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{01380}	Continued From page 14 The licensee's undated Staff Competency Evaluation policy indicated licensee would ensure staff would complete trainings in the areas listed above. No further information was provided.	{01380}		

Electronically Delivered

June 16, 2025

Licensee
A To Z Group Homes Limited
1067 12th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL37814016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $3,000.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

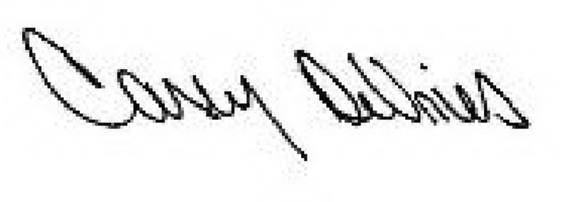
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/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: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37814	A. BUILDING: _____ B. WING _____	05/01/2025

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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: SL37814016-0 On April 28, 2025, through May 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license. An immediate correction order was identified on April 29, 2025, issued for SL37814016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk for tag identification 0775. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on April 30, 2025, issued for SL37814016-0, tag identification 1750. During the survey, the licensee took action to mitigate the immediate risk for tag identification	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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0 000	Continued From page 1 0775. However, noncompliance remained, and the scope and level remain unchanged.	0 000		
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	0 470		

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0 470	Continued From page 2 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, 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 April 28, 2025, at 9:48 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated the shift patterns for the assisted living facility (ALF) were 6:00 a.m., until 2:00 p.m., 2:00 p.m., until 10:00 p.m., and 10:00 p.m., until 6:00 a.m., and one unlicensed personnel (ULP) worked per shift. On April 28, 2025, at 10:21 a.m., during a facility tour, the surveyor observed a three-level ALF and did not observe the facility's staff plan. On April 28, 2025, at 2:39 p.m., CNS/LALD-C stated they were not aware of the staffing plan requirement. CNS/LALD-C stated they were told during a previous Minnesota Department of Health survey, the only statutory requirement was to have a staff schedule. The licensee's undated Shall Maintain These Minimum Requirements policy indicated licensee would develop a staffing plan to determine ALF	0 470		

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0 470	Continued From page 3 has sufficient staffing at all times to accommodate foreseeable unscheduled needs of residents. 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 operation provided soiled items do not contaminate clean items, surfaces, or food, and	0 480		

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0 480	Continued From page 4 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 or has the potential to affect a large portion or all the residents).	0 480		

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0 480	Continued From page 5 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 28, 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		
0 510 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 resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 6 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: On April 28, 2025, at 10:21 a.m., on the upper level of the three-level assisted living facility, the surveyor observed a bathroom with no paper towels for drying hands. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated it was a communal bathroom for residents, staff, and visitors. On April 29, 2025, at 10:14 a.m., the surveyor observed the bathroom on the upper level still lacked paper towels. On April 30, 2025, at 1:14 p.m., unlicensed personnel (ULP)-B stated staff were required to check the bathrooms each day and replace the paper towels in the bathroom. The surveyor observed ULP-B look for the paper towels in the bathroom on the upper level. ULP-B stated there were no paper towels located in the bathroom. On April 30, 2025, at 1:33 p.m., CNS/LALD-C stated they were responsible for the infection control practices for the facility, and they were aware communal bathrooms were required to have paper towels. CNS/LALD-C stated they were unsure why there were no paper towels. The licensee's undated, untitled policy indicated the licensee would observe recommended precautions for home care as identified by the Center for Disease Control (CDC).	0 510		

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0 510	Continued From page 7 The Center for Disease Control (CDC) About Hand Hygiene for Patients in Healthcare Settings website dated February 27, 2024, recommended using paper towels to dry hands after hand hygiene. 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 (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	0 630		

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0 630	Continued From page 8 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on June 14, 2023, and began receiving assisted living services. R3's Individual Abuse Prevention Plan dated April 16, 2024, lacked the following information: -the person's risk of abusing other vulnerable adults. On April 30, 2025, at 1:33 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the IAPP for R3. CNS/LALD-C stated they were aware the licensee was required to assess the resident's risk of abusing other vulnerable adults and stated they may have missed that part of the IAPP. The licensee's undated Vulnerable Adult/Child Protection policy indicated the licensee was required to assess resident's vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 9 (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 interview and record review, licensee failed to complete the facility tuberculosis (TB) risk assessment based on based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). 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 April 28, 2025, at 3:10 p.m., clinical nurse supervisor/licensed assisted living director	0 660		

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0 660	Continued From page 10 (CNS/LALD)-C provided a document titled Facility TB Risk assessment Worksheet for Health Care Setting Licensed by Minnesota Department of Health dated April 1, 2023. The licensee had no further Facility TB risk assessment worksheets completed for the assisted living facility (ALF). CNS/LALD-C stated they were unable to find the facility TB risks assessment worksheet for 2024. CNS/LALD-C stated they had not completed the facility TB risk assessment for 2025, as they believed it could be completed by the end of April 2025. The licensee's undated, untitled policy indicated the licensee would observe recommended precautions for home care as identified by the Center for Disease Control (CDC). The CDC's Tuberculosis Infection Control guidelines dated July 15, 2013, recommended conducting a TB risk assessment for the facility annually. The Minnesota Department of Health (MHD) Tuberculosis Screening dated December 13, 2024, recommended the assisted living facility (ALF) completed a TB risk assessment annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 660		
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	0 680		

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0 680	Continued From page 11 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 interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan 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).	0 680		

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0 680	Continued From page 12 The findings include: The licensee's undated EP plan, lacked evidence of the following required content: - annual review; -risk assessment should consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - risk assessment of various probably risks/hazards by likelihood of occurrence; - risk assessment of interruption of services and consider emerging infectious diseases; - population needs: independence, communication, transportation, supervision and medical care; - identify staff specific roles in another's absence through succession planning and delegation of authority; - developing and implemented EP policies/procedures based on the emergency plan, risk assessment and communication plan: addressing evacuated or shelter in place for staff and residents: food, water, medical supplies, pharmaceutical supplies, temperatures to protect resident health/safety, safe/sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems and sewage and waste disposal; - developing a plan for safe evacuation from the facility, including consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - policies and procedures for medication documentation;	0 680		

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0 680	Continued From page 13 - arrangements with other facilities/providers, including signed agreements; - roles under a waiver declared by secretary; - names and contact information for entities providing services under agreement, residents' physicians, other facilities, volunteers; - emergency officials contact information for Federal, State, Tribal, regional and local EP staff, State licensing and certification agency, Minnesota Office of Ombudsman for long-term care; - methods for sharing information; - sharing information on occupancy/needs; - long-term care (LTC) family notifications, and; - emergency prep training program. On April 28, 2025, at 3:10 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the EP plan. CNS/LALD-C stated they had been conducting fire drills every three months but had not updated the remaining part of the EP plan. CNS/LALD-C stated they were previously cited for lacking content during a survey conducted on April 20, 2023. CNS/LALD-C stated the plan of correction for the citation was to purchase the EP plan from a consultant company and to customize the EP plan to the facility. CNS/LALD-C believed the EP plan met the 144G statutes as they purchased it from a consultant company. The licensee's undated Emergency Preparedness policy indicated licensee would have an identified 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.	0 680		

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0 680	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=H	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 current State Fire Code in Minnesota Rules, chapter 7511. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents, staff, and visitors. 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: On April 29, 2025, from 10:15 a.m. to 11:00 a.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C . During the tour, the surveyor asked CNS/LALD-C to open the windows in the resident bedrooms for measurement. The	0 775		

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0 775	Continued From page 15 noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 3: One windows measuring 26 inches clear width, 23.5 inches clear height, and 611 square inches total open area. Bedroom 4: One windows measuring 26 inches clear width, 23.5 inches clear height, and 611 square inches total open area. The windows in bedrooms 3 and 4 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. At least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On April 29, 2025, the surveyor explained to CNS/LALD-C that an immediate correction order was issued for the above findings. CNS/LALD-C stated they understood the requirements for egress windows and would start the process of getting the windows replaced. TIME PERIOD FOR CORRECTION: Immediate	0 775		
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:	0 780		

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0 780	Continued From page 16 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation 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. 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	0 780		

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0 780	Continued From page 17 a large portion or all of the residents). The findings include: On April 29, 2025, from 10:30 a.m. to 11:30 a.m., the surveyor toured the facility with clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-C. The surveyor asked CNS/LALD-C to initiate a test of the smoke alarms throughout the home. Upon testing, the smoke alarm in bedroom 1 did not sound when the test button was pressed and all the smoke alarms in the facility were not interconnected. These deficient conditions were visually verified by CNS/LALD-C accompanying on the tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 18 (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and to provide the required training. 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 April 29, 2025, clinical nurse supervisor/	0 810		

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0 810	Continued From page 19 licensed assisted living director (CNS/LALD)-C 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, Fire Safety, undated, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. 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 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 the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On April 29, 2025, at 12:30 p.m., CNS/LALD-C stated they didn't any additional policies or procedures on fire safety and evacuation.	0 810		

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0 810	Continued From page 20 TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS/LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. CNS/LALD-C lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. The provided records were for fire safety training offered by third-party online software that could not be modified to include the facility-specific fire safety plans. CNS/LALD-C was unable to provide documentation showing any training completed or training scheduled for a future date for employees on the fire safety and evacuation plan. On April 29, 2025, at 12:30 p.m., CNS/LALD-C stated they did a basic fire safety training online as part of their annual training program for staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services	01370		

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01370	Continued From page 21 provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency	01370		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TO Z GROUP HOMES LIMITED	1067 12TH AVENUE SE MINNEAPOLIS, MN 55414

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01370	Continued From page 22 evaluations were completed for all required skill areas prior to providing services, for three of three unlicensed personnel (ULP)-A, ULP-B, 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 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: ULP-A ULP-A was hired October 24, 2024, to provide direct care services. ULP-A's employee record lacked evidence of the following: Trainings: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider, and; -awareness of commonly used health technology equipment and assistive devices. Competency evaluations: -standby assistance techniques and how to perform them. ULP-B ULP-B was hired on December 14, 2024, to provide direct care services. ULP-B's employee record lacked evidence of training for the following:	01370		

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01370	Continued From page 23 -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family, and; -awareness of commonly used health technology equipment and assistive devices. ULP-D ULP-D was hired on April 12, 2025, to provide direct care services. ULP-D's employee record lacked evidence of the following: Training: -documentation requirements for all services provided; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family, and; -awareness of commonly used health technology equipment and assistive devices. Competency evaluations: -standby assistance techniques and how to perform them. On April 30, 2025, at 9:58 a.m., via the language interpreter line, ULP-A stated they only worked the overnight shift. ULP-A stated they remembered completing some trainings online. ULP-A stated the nurse demonstrated many trainings but was unable to recall what the trainings were. ULP-A stated the nurse checked that ULP-A understood the training.	01370		

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01370	Continued From page 24 On April 30, 2025, at 1:14 p.m., ULP-B stated they remembered being shown how to use a gait belt and standby assistance techniques but did not remember the overall training process. The surveyor was unable to reach ULP-D for an interview. On May 1, 2025, at 9:31 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they used Educare (an online training program) for the trainings, and they relied on Educare's recommendation for the classes that should be completed. CNS/LALD-C stated they completed competencies in areas they believed the residents would require. CNS/LALD-C stated they were unaware of the specific trainings each ULP was required to have completed. The licensee's undated Staff Competency Evaluation policy indicated licensee would ensure staff would complete trainings in the areas listed above. No further information was provided.	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;	01380		

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01380	Continued From page 25 (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services for three of three unlicensed personnel (ULP)-A, ULP-B, 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 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: ULP-A ULP-A was hired October 24, 2024, to provide direct care services. ULP-A's employee record lacked evidence of training for the following: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; -recognizing physical, emotional, cognitive, and developmental needs of the resident.	01380		

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01380	Continued From page 26 ULP-B ULP-B was hired on April 12, 2025, to provide direct care services. ULP-B's employee record lacked evidence of training for the following: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; -recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-D ULP-D was hired on April 12, 2025, to provide direct care services. ULP-D's employee record lacked evidence of training for the following: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; -recognizing physical, emotional, cognitive, and developmental needs of the resident. On April 30, 2025, at 9:58 a.m., via the language interpreter line, ULP-A stated they only worked the overnight shift. ULP-A stated they remembered completing some trainings online. ULP-A stated the nurse demonstrated many trainings but was unable to recall what the trainings were. ULP-A stated the nurse checked that ULP-A understood the training. On April 30, 2025, at 1:14 p.m., ULP-B stated they remembered being shown how to use a gait belt and standby assistance techniques but did not remember the overall training process.	01380		

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01380	Continued From page 27 The surveyor was unable to reach ULP-D for an interview. On May 1, 2025, at 9:31 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they used Educare (an online training program) for the trainings, and they relied on Educare's recommendation for the classes that should be completed. CNS/LALD-C stated they completed competencies in areas they believed the residents would require. CNS/LALD-C stated they were unaware of the specific trainings each ULP was required to have completed. The licensee's undated Staff Competency Evaluation policy indicated licensee would ensure staff would complete trainings in the areas listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

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01620	Continued From page 28 individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an assessment that included all the content as required per Minnesota Administrative Rule 4659.0150 for two of three residents (R1, R2). Additionally, the licensee failed to complete 90-day assessments for one of three residents (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 the residents). The findings include: MISSING CONTENT FROM ASSESSMENTS R1 R1 was admitted to the facility on February 24,	01620		

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01620	Continued From page 29 2025, and began receiving assisted living services. R1's Service agreement plan dated February 24, 2025, indicated R1 received assistance with bathing, activities of daily living, laundry, light housekeeping, blood sugars, mediation administration, transportation, ambulation, meal preparation, and social activities. R1's diagnoses included alcohol abuse with alcohol induced mood disorder (a change in a person's mood based on the consumption of alcohol), and generalized anxiety disorder. R1's14-day assessment dated March 10, 2025, lacked the name of the registered nurse (RN) and signature. The following titled areas listed on the assessment form utilized by the licensee were documented as not assessed: -genitourinary (urine system and genitals)- uniform assessment tool requirements indicated toileting pattern, bowel, and bladder control must be assessed, and; -integument (skin)- uniform assessment tool requirements indicated skin conditions must be assessed. The following areas listed on R1's assessment and required to be included in the uniform assessment tool were left blank: -safety- uniform assessment tool requirements indicated to assess for risk for falls including history of falls and emergency evacuation ability; -vulnerability- uniform assessment tool requirements indicated to assess for risk for emotional or psychological distress due to personal losses; -medications- uniform assessment tool	01620		

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01620	Continued From page 30 requirements indicated to assess for any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; the dosage, the frequency of use, the route administered or taken, any difficulties the resident faces in taking the medication, whether the resident self-administers the medication, and the resident's preferences in how to take medication; -equipment- uniform assessment tool requirements indicated to assess for mobility, ambulation assistance, transfers, and assistive devices; -safety concerns- uniform assessment tool requirements indicated to assess for elopement risk including history or previous elopements, the ability to smoke without causing burns or injury to the resident or others or damage to property, alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; -psychosocial- uniform assessment tool requirements indicated to assess for emotional and mental health conditions, including: review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, current symptoms of mental health conditions and behavioral expressions of concerns; and effective medication treatment and nonmedication interventions including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders. R1's assessment lacked the following additional content that was required to be included per the uniform assessment tool: -the resident's personal lifestyle preferences, including: sleep schedule, dietary and social needs, leisure activities, and any other customary	01620		

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01620	Continued From page 31 routine that is important to the resident's quality of life; -spiritual and cultural preferences; -a review of relevant health history and current health conditions, including medical and nursing diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities were life threatening; -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; -a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -effective medication treatment and nonmedication interventions; -cognition, including: a review of any neurocognitive evaluations and diagnoses and -current memory, orientation, confusion, and decision-making status and ability; -communication and sensory capabilities, including hearing, vision, and speech; -assistive communication and sensory devices including hearing aids, and the ability to understand and be understood; -pain including: location, frequency, intensity, and duration; and effectiveness of medication and nonmedication; -nutritional and hydration status and preferences; -nursing needs, including potential to receive nursing-delegated services; -risk indicators, including: risk for falls including history of falls, emergency evacuation ability, complex medication regimen, risk for	01620		

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01620	Continued From page 32 dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, and elopement risk including history or previous elopements; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; -alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician and; -the need for follow-up referrals for additional medical or cognitive care by health professionals. R2 R2 was admitted to the facility on October 3, 2024, and began receiving assisted living services. R2's signed Service Agreement dated October 3, 2024, indicated R2 received assistance with bathing, activities of daily living, laundry, light housekeeping, blood sugars, mediation administration, transportation, ambulation, meal preparation, and social activities. R2's diagnoses included major depressive disorder (condition characterized by persistent feelings of sadness and a loss of interest or pleasure), anxiety disorder, dysthymic disorder (a form of chronic, low-grade depression that lasts for at least two years), alcohol dependance in remission, cocaine dependance, schizophrenia (condition characterized by a disconnection from reality, including experience hallucinations, delusions, and disorganized thinking), generalized anxiety disorder, essential hypertension (high blood pressure), post-traumatic stress disorder, type 2 diabetes (a	01620		

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01620	Continued From page 33 condition where the body cannot regular insulin correctly), and diabetic nephropathy (damage to the kidneys related to diabetes). R2's 90-day assessment dated January 3, 2025, lacked the name of the registered nurse (RN) and signature. The following titled areas listed on the assessment form utilized by the licensee were documented as not assessed: -genitourinary (urine system and genitals)- uniform assessment tool requirements indicated toileting pattern, bowel, and bladder control must be assessed, and; -integument (skin)- uniform assessment tool requirements indicated skin conditions must be assessed. The following areas listed on R2's assessment and required to be included in the uniform assessment tool were left blank: -safety- uniform assessment tool requirements indicated to assess for risk for falls including history of falls and emergency evacuation ability; -vulnerability- uniform assessment tool requirements indicated to assess for risk for emotional or psychological distress due to personal losses; -medications- uniform assessment tool requirements indicated to assess for any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; the dosage, the frequency of use, the route administered or taken, any difficulties the resident faces in taking the medication, whether the resident self-administers the medication, and the resident's preferences in how to take medication; -equipment- uniform assessment tool requirements indicated to assess for mobility, ambulation assistance, transfers, and assistive	01620		

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01620	Continued From page 34 devices; -safety concerns- uniform assessment tool requirements indicated to assess for elopement risk including history or previous elopements, the ability to smoke without causing burns or injury to the resident or others or damage to property, alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; -psychosocial- uniform assessment tool requirements indicated to assess for emotional and mental health conditions, including: review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, current symptoms of mental health conditions and behavioral expressions of concerns; and effective medication treatment and nonmedication interventions including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders. R2's assessment lacked the following additional content that was required to be included per the uniform assessment tool: -the resident's personal lifestyle preferences, including: sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; -spiritual and cultural preferences; -a review of relevant health history and current health conditions, including medical and nursing diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities were life threatening; -a review of medical, dental, and emergency	01620		

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01620	Continued From page 35 room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; -a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -effective medication treatment and nonmedication interventions; -cognition, including: a review of any neurocognitive evaluations and diagnoses and -current memory, orientation, confusion, and decision-making status and ability; -communication and sensory capabilities, including hearing, vision, and speech; and -assistive communication and sensory devices including hearing aids, and the ability to understand and be understood. ASSESSMENTS NOT COMPLETED R3 R3 was admitted to the facility on June 14, 2023, and began receiving assisted living services. R3's Master Care Plan dated April 16, 2024, indicated R3 received assistance with bathing, dressing, hygiene, mobility, case management, housekeeping, laundry needs, shopping, and mediation management. R3 diagnoses included hypertension. R3's record included an assessment dated April 16, 2024. The next assessment was required to be completed by July 15, 2024. There were no further assessments completed for R3. R3's record lacked documentation that assessments were attempted and declined.	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TO Z GROUP HOMES LIMITED	1067 12TH AVENUE SE MINNEAPOLIS, MN 55414

(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 36 On May 1, 2025, at 9:43 a.m., CNS/LALD-C stated they were responsible for the assessments for each resident. CNS/LALD-C stated they followed an assessment template provided from a consultant company to complete the assessments and would then enter the information into RTask (an electronic medical record). Additionally, CNS/LALD-C stated sometimes the residents declined being assessed but they did not document that. CNS/LALD-C stated it was hard to complete the assessments, and they would document not assessed if residents did not answer. CNS/LALD-C stated they were aware that assessments were required to be completed every 90 days. CNS/LALD-C stated RTasks prompted them every 180 days that the assessments were due and they were unsure how to change the assessment due dates from 180 to 90 days. CNS/LALD-C was unsure why R3's assessments were not completed. The licensee's undated Assessment - Comprehensive Service policy indicated resident will have an individualized assessment completed by the registered nurse (RN) and the assessment could be conducted every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 37 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required service plan content for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01650		

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01650	Continued From page 38 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 on February 24, 2025, and began receiving assisted living services. R1's signed Service Agreement Plan dated February 24, 2025, indicated R1 received assistance with bathing, activities of daily living, laundry, light housekeeping, blood sugars, mediation administration, transportation, ambulation, meal preparation, and social activities. The Service Plan lacked the following content: -the frequency of each service, according to the resident's current assessment and resident preferences. R2 R2 was admitted to the facility on October 3, 2024, and began receiving assisted living services. R2's signed Service Agreement Plan dated October 3, 2024, indicated R2 received assistance with bathing, activities of daily living, laundry, light housekeeping, blood sugars, mediation administration, transportation, ambulation, meal preparation, and social activities. The Service Plan lacked the following content: -the frequency of each service, according to the resident's current assessment and resident preferences.	01650		

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01650	Continued From page 39 On May 1, 2025, at 9:16 a.m., and 9:59 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they did not have a policy for service plans, and they were unaware the service plans lacked required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, 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; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional	01730		

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01730	Continued From page 40 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 interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the facility on February 24, 2025, and began receiving assisted living	01730		

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01730	Continued From page 41 services. R1's Service agreement plan dated February 24, 2025, indicated R1 received assistance with medication administration. R1's record lacked the following information: - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R3 R3 was admitted to the facility on June 14, 2023, and began receiving assisted living services. R3's Master Care Plan dated April 16, 2024, indicated R3 received assistance with medication administration. R3's record lacked the following information: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions, and; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On May 1, 2025, at 10:01 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the medication management plans for the residents. CNS/LALD-C stated they were unaware of the required content, and they believed the medication management plans had all the required information. The licensee's undated Medication Manage	01730		

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01730	Continued From page 42 Program subsection 5 Individualize Medication Management Plan indicated the plan would include the above information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained in the proper methods to perform the task or procedure for each resident and verified the ULP was able to demonstrate the ability to competently follow the procedure for one of three employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

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01750	Continued From page 43 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 R1's record contained a document titled List of Services to be Provided dated February 24, 2025, which indicated R1 received assistance with medication administration. R1's Medication Administration Record (MAR) dated April 1, 2025, through April 30, 2025, indicated R1 received the following medication on an as needed (PRN) basis: melatonin tablet, and senna concentrate/docusate sodium. R4 R4's record contained a document titled List of Services to be Provided dated January 25, 2025, which indicated R4 received assistance with medication administration. R4's MAR dated April 1, 2025, through April 30, 2025, indicated R4 received the following medications on a PRN basis: methocarbamol, ondansetron, Proair, risperidone, Senexon-S, acetaminophen 500 milligrams (mg), and Albuterol 0.083 percent (%) inhaler. R5 R5's record contained a document titled List of Services to be Provided dated January 25, 2025, which indicated R5 received assistance with medication administration.	01750		

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01750	Continued From page 44 R5's MAR dated April 1, 2025, through April 30, 2025, indicated R5 received the following medications on a PRN basis: acetaminophen 500 mg, senna, and Ventolin inhaler. ULP-A was hired October 24, 2024, to provide direct care services. The licensee's Employee Shift Schedule dated April 2025, indicated ULP-A worked the overnight shift. ULP-A's employee record included an Educare transcript (online training program) that indicated ULP-A completed two training classes related to medications titled Medication Administration - Overview and Medication - Routes. ULP-A's employee file lacked documentation of a competency evaluation for medication administration. On March 28, 2025, at 9:48 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated the shift patterns for the assisted living facility (ALF) were 6:00 a.m. until 2:00 p.m., 2:00 p.m., until 10:00 p.m. and 10:00 p.m. until 6:00 a.m., and one ULP worked per shift. There was no staff member working the overnight shift that had a medication competency. The ALF census was five residents, with the last medication due for administration at 9:45 p.m., to R2. The remaining medications were PRN medications. On April 30, 2025, at 9:58 a.m., via the language interrupter line, ULP-A stated they only worked the overnight shift. ULP-A stated they were informed by CNS/LALD-C there were no medications to be administered on the night shift. ULP-A stated they were trained to call	01750		

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01750	Continued From page 45 CNS/LALD-C if a resident requested medications. ULP-A stated the training they received for medication administration were the online trainings, and CNS/LALD-C went over the steps on how to administer medications. ULP-A stated they had not administered medications or any as needed medications while working for the licensee. On April 30, 2025, at 10:37 a.m., CNS/LALD-C stated they were responsible for training staff related to medication administration. CNS/LALD-C stated ULP-A completed Educare courses in medication administration. CNS/LALD-C stated ULP-A observed CNS/LALD-C administer medications to residents. CNS/LALD-C stated ULP-A did not demonstrate they were competent at medication administration, as there were no medications to administer. CNS/LALD-C stated they trained ULP-A to call CNS/LALD-C if a medication was requested or they would come to the facility and administer the medication. On April 30, 2025, at 11:27 a.m., CNS/LALD-C stated ULP-A worked five overnight shifts each week. The licensee's undated Staff Competency Evaluation policy indicated would complete a competency evaluation in areas including medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01820 SS=E	144G.71 Subd. 13 Prescriptions	01820		

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01820	Continued From page 46 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 maintain current medication orders for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the facility on February 24, 2025, and began receiving assisted living services. R1's diagnoses included alcohol abuse with alcohol induced mood disorder (a change in a person's mood based on the consumption of alcohol), and generalized anxiety disorder. R1's Service Agreement Plan dated February 24, 2025, indicated R1 received assistance medication administration. R1's Medication Administration Record (MAR)	01820		

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01820	Continued From page 47 dated April 1, 2025, through April 30, 2025, indicated R1 received the following medications: acamprosate calcium 333 milligram (mg) 2 tablets 3 times daily, duloxetine 60 mg 2 capsules once daily, gabapentin 300 mg 1 capsule three times daily, naltrexone 50 mg 1 tablet once daily, folic acid 1000 micrograms (mcg) 1 tablet once daily, amoxicillin 500 mg 1 tablet daily once daily, ketoconazole 2 percent (%) apply topically (on the skin) to areas on face, quetiapine 50 mg 1 tablet once daily, trazadone 100 mg 1 tablet once daily, melatonin 1 tablet at bedtime as needed, and senna concentrate/docusate 1 tablet once daily. R1's record included a document title After Visit Summary (AVS) dated April 7, 2025. The AVS indicated R1 was prescribed the following medications: acamprosate calcium 333 milligram (mg) 2 tablets 3 times daily, duloxetine 60 mg 2 capsules once daily, gabapentin 300 mg 1 capsule three times daily, naltrexone 50 mg 1 tablet once daily, folic acid 1000 micrograms (mcg) 1 tablet once daily, ketoconazole 2 percent (%) apply topically (on the skin) to areas on face, quetiapine 50 mg 1 tablet once daily, and trazadone 100 mg 1 tablet once daily. R1's AVS lacked signature from a medical prescriber. R3 R3 was admitted to the facility on June 14, 2023, and began receiving assisted living services. R3's Master Care Plan dated April 16, 2024, indicated R3 received assistance with medication administration. R3's MAR dated April 1, 2025, through April 30, 2025, indicated R3 received the following	01820		

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01820	Continued From page 48 medications: amlodipine 5 mg 1 tablet once daily, atenolol 25 mg one-half tablet twice daily, atorvastatin 10 mg 1 tablet once daily, ferrous sulfate 325 1 tablet on Monday, Wednesday and Friday, Vitamin D3 25 mcg 1 tablet once daily, estrodiol 2 grams apply vaginally every Monday and Friday. R3's record included five prescriptions dated November 22, 2023, for the following medications: lipitor 10 mg 1 tablet once daily, atenolol 50 mg 1 tablet twice daily, duloxetine 20 mg 1 capsule once daily, and acetaminophen extra strength 500 mg 2 tablets twice daily. R3's record lacked a signed order from a medical prescriber for the following medications: amlodipine 5 mg 1 tablet once daily, ferrous sulfate 325 1 tablet on Monday, Wednesday and Friday, Vitamin D3 25 mcg 1 tablet once daily, and estrodiol 2 grams apply vaginally every Monday and Friday. On May 1, 2025, at 10:07 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the prescriber orders for residents. CNS/LALD-C stated they were aware a signed order from a medical provider was required to be kept on file. CNS/LALD-C stated they believed R1's AVS was signed, and they were unsure why there were missing prescription orders for R3. The licensee undated Prescription policy indicated licensee would not administer any medication without a physician's prescription for that medication. No further information was provided.	01820		

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01820	Continued From page 49 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the facility on June 14, 2023, and began receiving assisted living services. R3's diagnoses included hypertension (high blood pressure). R3's Master Care Plan dated April 16, 2024, indicated R3 received assistance with medication administration.	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37814	A. BUILDING: _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TO Z GROUP HOMES LIMITED	1067 12TH AVENUE SE MINNEAPOLIS, MN 55414

(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
01830	Continued From page 50 R3's medication administration record (MAR) dated April 1, 2025, through April 30, 2025, indicated R3 received the following medications: amlodipine 5 milligram (mg) 1 tablet once daily, atenolol 25 mg one-half tablet twice daily, atorvastatin 10 mg 1 tablet once daily, ferrous sulfate 325 1 tablet on Monday, Wednesday and Friday, Vitamin D3 25 microgram (mcg) 1 tablet once daily, estrodiol 2 grams apply vaginally every Monday and Friday. R3's record included signed medication prescription orders dated November 22, 2023. R3's record lacked current signed orders from a medical provider dated within a 12-month period. On May 1, 2025, at 10:07 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the prescriber orders for residents. CNS/LALD-C stated they were unsure why there were missing prescription orders for R3. The licensee's undated Renewal of Prescriptions policy indicated licensee will renew all resident prescriptions as needed and will not exceed a 12-month interval between refills. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
02290 SS=D	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37814	A. BUILDING: _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TO Z GROUP HOMES LIMITED	1067 12TH AVENUE SE MINNEAPOLIS, MN 55414

(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
02290	Continued From page 51 require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to protect the rights of a resident when staff imposed a restriction which limited the rights of one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on February 24, 2025, and began receiving assisted living services. R1's diagnoses included alcohol abuse with alcohol induced mood disorder (a change in a persons mood based on the consumption of alcohol), and generalized anxiety disorder. R1's record included a progress note dated April 27, 2025, at 9:23 p.m., which indicated staff observed R1 to be intoxicated, R1 became agitated, staff removed the alcohol from R1, and the nurse was notified. R1's record lacked a documented service plan with instructions for staff to follow if R1 appeared	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37814	A. BUILDING: _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TO Z GROUP HOMES LIMITED	1067 12TH AVENUE SE MINNEAPOLIS, MN 55414

(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
02290	Continued From page 52 to be intoxicated. On April 28, 2025, at 1:48 p.m., R1 stated staff had removed their alcohol from their possession. R1 stated they did not agree with staff that the alcohol could be removed. On April 28, 2025, at 1:57 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they could not find the documented written interventions for R1. CNS/LALD-C stated they had a verbal conversation with R1 about allowing staff to remove the alcohol but did not document that in R1's file. On April 28, 2025, at 2:04 p.m., unlicensed personnel (ULP)-D stated they were trained to remove the alcohol from R1 if they appeared to be intoxicated and to contact the CNS. ULP-D stated if they left the alcohol with R1, they would continue to consume it. On April 30, 2025, at 1:45 p.m., social worker (SW)-E stated they were R1's social worker since 2023. SW-E stated they were aware that alcohol had been removed from R1's possession, and there was not an agreed and signed care plan with R1 related to the intoxication and removal of alcohol. On May 1, 2025, at 9:16 a.m. and 10:19 a.m., CNS/LALD-C stated they did not have a specific policy on service plans. CNS/LALD-C stated there was no written acknowledgement or documentation of the planned intervention with R1. CNS/LALD-C stated they were unaware a care plan was required to be signed and agreed upon with R1 that would allow staff to remove alcohol if R1 appeared intoxicated.	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37814	A. BUILDING: _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A TO Z GROUP HOMES LIMITED	1067 12TH AVENUE SE MINNEAPOLIS, MN 55414

(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
02290	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

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

Food & Beverage Inspection Report

Establishment Info

A to Z Group Homes Limited
1067 12th Avenue SE
Minneapolis, MN 55414
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37814

Risk:
License:
Expires on:
CFPM: Zohara A. Harun
CFPM #: FM108931; Exp: 12/2/2027

Inspection Info

Report Number: F1050251003
Inspection Type: Full - Single
Date: 4/28/2025 Time: 10:30:38 AM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE. COPY OF LOG SENT WITH REPORT. PRINT AND KEEP ILLNESS LOG ON SITE AND UP TO DATE. COMPLY WITH RULE ABOVE.
Comply By: 4/28/2025 Originally Issued On: 4/28/2025

! **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: POTATO SALAD MEASURED 46F. DISCUSSED ENSURING ALL FOODS NEEDING TEMPERATURE CONTROL ARE STORED AT 41F OR BELOW.

REACH-IN COOLER WAS CORRECTED TO RECOMMENDED SETTING.

OPERATOR REMOVED AND DISCARDED 4/28/25.
Comply By: 4/28/2025 Originally Issued On: 4/28/2025

Food & Beverage General Comment

Unannounced inspection completed by MDH Andrew Spaulding and Operator on 4/28/25.

Discussed food source, ware washing, pest control, illness policy and food handling procedures.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1050251003 from 4/28/2025

Zohara A. Harun
Operator

Andrew Spaulding,
Public Health Sanitarian 2
651-201-5298

andrew.spaulding@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

A to Z Group Homes Limited
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1050251003
Inspection Type: Full
Date: 4/28/2025
Time: 10:30:38 AM

Food Temperature: Product/Item/Unit: Potato Salad**; Temperature Process:** Cold-Holding
Location: Reach in at 46 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Reach in at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cheese **; Temperature Process:** Cold-Holding
Location: Reach in at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

A to Z Group Homes Limited
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1050251003
Inspection Type: Full
Date: 4/28/2025
Time: 10:30:38 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
Location: Kitchen **Equal To** 165 Degrees F.
Comment:
Violation Issued?: No