DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

April 17, 2026

Licensee
NG&NG SERVICES GROUP LLC
14311 Aspen Avenue
Rosemount, MN 55068

RE: Provisional Conditional License Number 419323
Health Facility Identification Number (HFID) 41368
Project Number(s) SL41368015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 4, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 17, 2026**.

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

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval.
The correction order documentation should include the following:

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

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH 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.

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

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional

license.

b. No new admissions: NG&NG SERVICES GROUP LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. NG&NG SERVICES GROUP LLC must provide the Department:

i. A list of the names and birthdates of any individuals NG&NG SERVICES GROUP LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents including:
   1. Name and birthdate of each resident
   2. Current payment source for services
   3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
   4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: NG&NG SERVICES GROUP LLC will contract with an RN to provide consultation concerning all resident(s) to whom NG&NG SERVICES GROUP LLC provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from NG&NG SERVICES GROUP LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with NG&NG SERVICES GROUP LLC and MDH must review the RN's credentials and approve the selection. NG&NG SERVICES GROUP LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to NG&NG SERVICES GROUP LLC in an effort to help NG&NG SERVICES GROUP LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. NG&NG SERVICES GROUP LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies NG&NG SERVICES GROUP LLC and the RN consultant about a change. Each report will be electronically submitted to: **HRDConsultantReports.MDH@state.mn.us**. The content of the reports will

include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of NG&NG SERVICES GROUP LLC to correct the violations cited during the survey as well as to determine the overall practice of NG&NG SERVICES GROUP LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up , MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan: NG&NG SERVICES GROUP LLC** will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if NG&NG SERVICES GROUP LLC is in substantial compliance based on the results

of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determinesNG&NG SERVICES GROUP LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to NG&NG SERVICES GROUP LLC. If MDH determines NG&NG SERVICES GROUP LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Jodi Johnson directly at: 507-344-2730 or email at: Jodi.Johnson@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41368	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NG AND NG SERVICES GROUP LLC	14311 ASPEN AVENUE ROSEMOUNT, MN 55068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER 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: SL41368015-0 On March 2, 2026, through March 4, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 3, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-I, clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment dated December 1, 2025, indicated the licensee was a low risk. ULP-I ULP-I was hired on July 15, 2025, to provide direct care services for the licensee's residents. ULP-I's employee's record contained a first-step TST administered on July 3, 2025, and read on July 6, 2025. ULP-I's employee record did not include evidence that a second step TST had been completed. CNS-C CNS-C was hired on November 1, 2025, to provide direct care services for the licensee's residents. CNS-C's employee's record contained a first-step TST administered on October 11, 2025, and read on October 13, 2025. CNS-C's employee record did not include evidence that a second step TST had been completed. On March 4, 2026, at 1:08 p.m., CNS-C stated she had only completed a one step TST as that was all the licensee required from her. CNS-C further stated ULP-I also only completed the first step TST.	0 660		

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0 660	Continued From page 5 The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). The 2-step TST identified as: Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected. The licensee's undated, TB Prevention and Control policy indicated: 3. Staff Screening & Testing: staff refers to all paid employees, unpaid employees, contractors, students, and regularly scheduled volunteers. a. Upon hire staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is	0 660		

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0 660	Continued From page 6 potential contact or shared space with resident until TB testing and screening is completed and a negative TB test is provided. i. If the first step of the two-step TST is negative the employee may begin working with residents (if the TST is dated within 90 days before hire) but must have the second TST test within 21 days after hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the	0 730		

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0 730	Continued From page 7 resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	0 730		

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0 730	Continued From page 8 The findings include: R2 was admitted to the licensee on April 11, 2025, with diagnoses including congenital malformations of skin, chronic pain syndrome, generalized anxiety disorder, and history of malignant neoplasm of the bronchus and lung. R2 discharged from the facility on February 2, 2026. R2's record lacked a discharge summary to include: - course of illnesses - treatments and therapies - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On March 4, 2026, at 9:18 a.m., clinical nurse supervisor (CNS)-C stated she had not completed a discharge summary with the required content for R2 following discharge. The licensee's undated, Discharge Summary policy indicated: 1. A discharge summary will be written by the time of discharge. 2. The facility will provide the resident with a written discharge summary at the time of discharge. 3. If the resident consents, the facility will provide the resident's representative and case manager a written discharge summary at the time of discharge. 4. The discharge summary will include, if applicable,	0 730		

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0 730	Continued From page 9 a. Summary of the resident's stay, including i. Diagnosis ii. Courses of illnesses iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab results vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 775		

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	41368	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NG AND NG SERVICES GROUP LLC	14311 ASPEN AVENUE ROSEMOUNT, MN 55068

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0 775	Continued From page 10 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 800		

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0 800	Continued From page 11 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 12 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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 810		

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0 810	Continued From page 13 March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 14 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation when the residents had not returned to the facility within four days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's diagnoses included type II diabetes mellitus, low back pain, and fracture of left ankle. R1's Resident Service Plan signed October 20, 2025, included medication administration assistance with grooming, bathing,	01060		

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01060	Continued From page 15 transfers,behavior management, housekeeping, and laundry. R1's After Visit Summary dated October 22, 2025, indicated R1 had been hospitalized on October 18, 2025, and discharged on October 22, 2025. R1's incident report dated December 29, 2025, indicated R1 had a fall in her room resulting in a left ankle fracture and hospitalization. R1's progress notes indicated R1 required surgery and was subsequently transferred to a transitional care unit (TCU) on January 7, 2026. R1 returned to the licensee on January 21, 2026. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On March 3, 2026, at 3:52 p.m., licensed assisted living director (LALD)-A stated the licensee did not provide an emergency transfer notice to resident, legal representative, and designated representative when residents were hospitalized,	01060		

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01060	Continued From page 16 nor were they notifying the ombudsman when the relocation exceeded four days. LALD-A stated being cited for this at a sister facility but was unsure on how to correct. LALD-A further stated being unaware of the requirement to contact the ombudsman if the relocation exceed four days. The licensee's undated, Contract Termination policy indicated: 8. Emergency relocation A. This facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. B. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (b) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal. (6) The notice required will be delivered as soon as practicable to: a) the resident, legal representative, and	01060		

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01060	Continued From page 17 designated representative; b) for residents who receive home and community-based waiver services under the resident's case manager; and c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received an	01290		

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01290	Continued From page 18 affiliation with the assisted living license for five of 12 employees (unlicensed personnel (ULP)-D, ULP-E, ULP-G, ULP-H, and house manager (HM)-F). 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: ULP-D ULP-D was hired March 29, 2025, to provide direct care and services to the licensee's residents. On March 3, 2026, at 8:26 a.m., the surveyor observed ULP-D administering medications to R3. ULP-D's employee record contained a background study dated November 5, 2023, for a different assisted living facility operated by the licensee's owner. ULP-D's employee record lacked evidence the licensee affiliated a background study for this assisted living facility license. ULP-E ULP-E was hired March 29, 2025, to provide direct care and services to the licensee's residents. ULP-E's employee record contained a	01290		

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01290	Continued From page 19 background study dated November 5, 2023, for a different assisted living facility operated by the licensee's owner. ULP-E's employee record lacked evidence the licensee affiliated a background study for this assisted living facility license. ULP-G ULP-G was hired March 29, 2025, to provide direct care and services to the licensee's residents. ULP-G's employee record contained a background study dated November 5, 2023, for a different assisted living facility operated by the licensee's owner. ULP-G's employee record lacked evidence the licensee affiliated a background study for this assisted living facility license. ULP-H ULP-H was hired March 29, 2025, to provide direct care and services to the licensee's residents. ULP-H's employee record contained a background study dated February 2, 2024, for a different assisted living facility operated by the licensee's owner. ULP-H's employee record lacked evidence the licensee affiliated a background study for this assisted living facility license. HM-F HM-F was hired March 29, 2025, to provide direct care and services to the licensee's residents. HM-F's employee record contained a background study dated November 5, 2023, for a different assisted living facility operated by the licensee's	01290		

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01290	Continued From page 20 owner. HM-F's employee record lacked evidence the licensee affiliated a background study for this assisted living facility license. On March 2, 2026, at 4:05 p.m., the surveyor reviewed the NETStudy 2.0 employee roster for this licensee's Health Facility identification (HFID) number 41368, with licensed assisted living director (LALD)-A. LALD-A stated ULP-D, ULP-E, ULP-G, ULP-H, and HM-F were not included on the employee roster as they were also employed at a sister facility (HFID 37927) run by the same owners, and would have had their background study completed through that HFID number. LALD-A was unaware of the requirement to affiliate the background study for the above employees with this licensee. The licensee's undated, Background Checks policy indicated: All employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS (Department of Human Services). Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	01470		

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01470	Continued From page 21 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;	01470		

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01470	Continued From page 22 (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-I) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-C CNS-C was hired on November 1, 2025, to provide direct care services to the licensee's residents and provided oversight and supervision	01470		

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01470	Continued From page 23 of nursing tasks. CNS-C's employee record did not include the following required orientation content: - an overview of the 144G statutes - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of resident's complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On March 4, 2026, at 1:18 p.m. CNS-C reviewed her training record and stated the above trainings had not been completed. ULP-I ULP-I was hired on July 15, 2025, to provide direct care and services to the licensee's residents. ULP-I's employee record did not include the following required orientation content: - an overview of the 144G statutes - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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	41368	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NG AND NG SERVICES GROUP LLC	14311 ASPEN AVENUE ROSEMOUNT, MN 55068

(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
01470	Continued From page 24 person; - handling of resident's complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services. On March 4, 2026, at 2:31 p.m., licensed assisted living director (LALD)-A reviewed ULP-I's training record and stated the above trainings had not been completed. The licensee's undated, Assisted Living & Assisted Living With Memory Care Orientation - All Staff policy indicated: 1. All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia	01530		

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01530	Continued From page 25 topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees	01530		

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01530	Continued From page 26 (clinical nurse supervisor (CNS)-C) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: CNS-C was hired on November 1, 2025, to provide direct care services to the licensee's residents and provided oversight and supervision of nursing tasks. CNS-C's employee record lacked evidence of completion of eight hours of dementia care training within 120 hours of the employment start date as required. On March 4, 2026, at 1:08 p.m., CNS-C stated she had not completed any dementia training upon hire as the trainings had not been assigned to her. The licensee's undated, Assisted Living Dementia Training policy indicated: 2. Assisted Living licensed settings A. Orientation i. Supervisors of direct-care staff will: 1. complete a minimum of 8 hours initial training on dementia care topics 2. initial training will be completed within 120 working hours of the employment start	01530		

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01530	Continued From page 27 date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R1).	01640		

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01640	Continued From page 28 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 on September 2, 2025, with diagnoses including type II diabetes mellitus, low back pain, and fracture of left ankle. On March 2, 2026, at 2:31 p.m., the surveyor observed R1 lying in bed in her room. R1 was utilizing oxygen via nasal cannula through an oxygen concentrator; a Hoyer lift was also observed in R1's room. R1 stated she needed the Hoyer lift for transfers; although, often she preferred to stay in bed. R1 further stated she utilized a bedpan for toileting which staff assisted her with; staff also assist her with repositioning in bed. R1's incident report dated December 29, 2025, indicated R1 had a fall in her room resulting in a left ankle fracture and hospitalization. R1's progress notes indicated R1 required surgery and was subsequently transferred to a transitional care unit (TCU) on January 7, 2026. R1 returned to the licensee on January 21, 2026. R1's Services Delivered forms dated February 1, 2026, through March 2, 2026, included the following services: Hoyer lift transfer, oxygen delivery, incontinence care, escort/mobility	01640		

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01640	Continued From page 29 assistance, position/re-position. R1's Master Care Plan dated February 26, 2026, indicated the following: - Needs assistance with turning and repositioning. Assist of one to two with turning and repositioning due to size and external pins in left leg fracture. - Needs a assistive device to transfer - Hoyer lift. Assist of two with Medline Hoyer lift. - Needs help with oxygen equipment. On continuous oxygenation 2 L/Min (two liters per minute) as ordered. - Needs assistance with toileting. Assist of one to two and bed pan for stool. Voiding in brief. - Needs assistance with incontinence products R1's Resident Service Plan signed October 20, 2025, included the following services: continence care - staff to schedule bathroom, transferring-staff to assist, one person assist. The service plan further indicated "N/A" (not applicable) for assistance with wheeling and repositioning. The service plan did not include assistance with oxygen therapy. On March 3, 2026, at 2:08 p.m., administrator/unlicensed personnel (A/ULP)-B reviewed R1's service plan and stated it had not been revised and signed by the resident when services changed following a change in condition. The licensee's undated, Contents of Service Plans policy indicated: All assisted living residents have a up-to-date service plan identifying services to be provided based on the assessment by the RN (registered nurse) and/or other licensed health professional. 4. Service plan are reviewed and revised as needed based upon on-going resident assessment.	01640		

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01640	Continued From page 30 No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons 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	01650		

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01650	Continued From page 31 by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for one of one resident (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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's service plan dated October 22, 2025, indicated R1 received services including dressing, grooming, bathing, transfers, medication management/administration, blood glucose monitoring, behavior management, housekeeping, and laundry. R1's service plan lacked the following: - the schedule and methods of monitoring assessments of the resident; the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - action to be taken if the scheduled service cannot be provided; - 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 - the circumstances in which emergency	01650		

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01650	Continued From page 32	01650		

medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

On March 3, 2026, at 3:52 p.m., licensed assisted living director (LALD)-A and administrator/unlicensed personnel (A/ULP)-B reviewed R1's service plan and it did not include the above required content. LALD-A and A/ULP-B further stated the same service plan format was utilized for all residents.

The licensee's undated, Contents of Service Plans policy indicated:
5. Service plans will include:
a. A description of the services to be provided
d. Schedule and methods of monitoring assessments
e. Schedule and methods of monitoring staff providing services
f. Contingency plan
g. A contingency plan that includes:
i. Action taken if the scheduled service cannot be provided
ii. Information and method to contact the facility
iii. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition
v. Identification of and information on who has authority to sign for the resident in an emergency
vi. Circumstances in which emergency medical services are not to be summoned

No further information was provided.

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01650	Continued From page 33 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (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: During the entrance conference on March 2, 2026, at 1:00 p.m., clinical nurse supervisor	01710		

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01710	Continued From page 34 (CNS)-C stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included type II diabetes mellitus, low back pain, and fracture of left ankle. R1's Resident Service Plan signed October 20, 2025, included medication administration. R1's provider orders dated January 14, 2026, included the following order: Polyvinyl Alcohol Ophthalmic Solution 1.4% Instill one drop in both eyes two times a day for dry eyes. R1's comprehensive nursing assessment dated February 26, 2026, indicated staff administer and document medications based on doctors order/MAR (medication administration record) except PRN (as needed) Albuterol inhaler, may self administer PRN every four hours, six times per day as needed. The assessment also indicated R1 may self apply topical medications. The assessment further indicated R1 could not correctly administer eye drops. On March 3, 2026, at 8:52 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up and administering R1's morning medication including eye drops. ULP-E stated R1 was able to administer her own eye drops, then handed R1 the eye drop bottle; R1 instilled one drop into each eye independently with no concerns observed. On March 3, 2026, at 9:47 a.m., CNS-C reviewed R1's medication assessment and stated it did not include assessment of R1 being able to administer her own eye drops; only rescue inhaler and topical medication.	01710		

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01710	Continued From page 35 The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated: The Assisted Living Facility will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of three	01760		

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01760	Continued From page 36 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's diagnoses included type II diabetes mellitus, low back pain, and fracture of left ankle. R1's Resident Service Plan signed October 20, 2025, included medication administration. R1's provider orders dated January 14, 2026, included: Lidocaine external patch 5% (Lidocaine). Apply to affected area topically one time a day for pain and remove per schedule. R1's medication administration record (MAR) dated March 2026, included the above order, and further directed staff to apply one patch every morning and remove in the PM to prevent lidocaine toxicity (on for 12 hours, then off for 12 hours). The MAR further had been signed off on March 2, 2026, at 8:35 p.m. that R1's patch had been removed. On March 3, 2026, at 8:52 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up R1's morning medications including the lidocaine patch. The pharmacy label on the patch indicated: Lidocaine 5% patch. Apply one patch and remove once daily. On for 12 hours and off	01760		

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01760	Continued From page 37 for 12 hours; lower back pain. At 9:18 a.m., the surveyor observed ULP-E removing a lidocaine 5% patch from R1's left knee, then applying the new lidocaine patch. ULP-E stated the evening shift should have removed the old patch and didn't. ULP-E further stated they used to apply the patch to R1's lower back, though since R1's surgery to her left leg, R1 had requested staff apply it to her left knee instead. ULP-E stated staff place the patch wherever R1's wants it, and the nurse is aware of this. On March 3, 2026, at 9:46 a.m., clinical nurse supervisor (CNS)-C stated R1's lidocaine patch was ordered for her lower back and had just observed the patch on R1's left knee. CNS-C further stated being unaware staff had been putting the patch on R1's left knee rather than her lower back and should have notified CNS-C of R1's request. CNS-C also stated the evening shift is responsible for removing R1's lidocaine patch, and ULP-E should have notified CNS-C that the patch had not been removed prior to placing a new patch. The licensee's 7.24 Medication Error policy dated August 1, 2021, indicated: Whenever a medication error occurs, the person responsible for the error or the person who caught the medication error will: 1. Contact a licensed nurse and explain the situation in detail wit the medications name, dosage and amount given as well as the resident involved. 2. The licensed nurse will instruct the staff person on what to do next. This may include contacting the prescriber, family and /or 911. 3. If the staff on duty is unable to have timely two-way communication with a licensed nurse, the staff person will immediately contact the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41368	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NG AND NG SERVICES GROUP LLC	14311 ASPEN AVENUE ROSEMOUNT, MN 55068

(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
01760	Continued From page 38 prescriber and explain in detail the medication give, the dosage and amount. The staff person will document exactly what the prescriber stated and any orders and then will carry out the orders. 4. The staff person involved will then complete a medications error report and document in the resident's record progress notes what occurred, date and time, who was contacted and what the actions were to correct the situation. 5. If the licensed nurse was unavailable, leave a detailed message on the voice mail. 6. The completed Medication Error Report Form will be left in the designated licensed nurse in-box for review. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of three residents (R1) observed during medication administration. 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	01880		

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01880	Continued From page 39 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's diagnoses included type II diabetes mellitus, low back pain, and fracture of left ankle. R1's Resident Service Plan signed October 20, 2025, included medication administration. R1's medication administration record (MAR) dated March 2026, included the following orders: - Zinc oxide ointment 20%. Apply topically to affected areas twice daily - Nystain powder 1000000. Apply topically to skin folds twice daily and as needed with toileting R1's comprehensive nursing assessment dated February 26, 2026, indicated staff administer and document medications based on doctors order/MAR (medication administration record) except PRN (as needed) Albuterol inhaler, may self administer PRN every four hours, six times per day as needed, and indicated inhaler is kept with resident. The assessment further indicated staff do not leave medications by the bedside. On March 3, 2026, at 8:52 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up and administering R1's morning medications. Upon entering R1's room, the surveyor observed R1's albuterol inhaler, zinc oxide, and Nystatin powder on her bedside table. On March 3, 2026, at 9:47 a.m., clinical nurse supervisor (CNS)-C stated R1's zinc oxide and	01880		

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01880	Continued From page 40 Nystatin powder should not have been kept at R1's bedside and should be locked in the medication cart. The licensee's undated, Storage of Medications policy indicated: 1. A registered nurse must conduct a face to face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the RN will develop an individualized medication management plan for the resident that will address storage of the resident's medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	01910		

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01910	Continued From page 41 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R2 was admitted to the licensee on April 11, 2025, with diagnoses including congenital malformations of skin, chronic pain syndrome, generalized anxiety disorder, and history of malignant neoplasm of the bronchus and lung. R2 discharged from the facility on February 2, 2026.	01910		

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01910	Continued From page 42 R2's undated, Service Plan indicated the resident received services including medication administration. R2's record did not include a reconciliation of medications upon discharge. On March 4, 2026, at 9:18 a.m., CNS-C stated she was unaware of the requirement to record the disposition of medications when a resident discharged from the facility with their medications. CNS-C further stated she only completed the disposition of medication for medications that were destroyed. The licensee's undated, Disposition or Disposal of Medication policy indicated: 1. Drugs Given to Residents When the Medication Management Services Have Been Terminated a. A resident's current medications that are secured or stored by our facility will be given to the resident or the resident's representative when the resident's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a resident will be given to the resident or the resident's representative. b. Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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02320	Continued From page 43	02320		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of one unlicensed personnel (ULP)-E observed during medication administration. 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 R1's diagnoses included type II diabetes mellitus, low back pain, and fracture of left ankle. R1's Resident Service Plan signed October 20, 2025, included medication administration. R1's provider orders dated January 14, 2026,	02320		

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02320	Continued From page 44 included: Lidocaine external patch 5% (Lidocaine). Apply to affected area topically one time a day for pain and remove per schedule. R1's medication administration record (MAR) dated March 2026, included the above order, and further directed staff to apply one patch every morning and remove in the PM to prevent lidocaine toxicity (on for 12 hours, then off for 12 hours). On March 3, 2026, at 8:52 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up R1's morning medications including the lidocaine patch. The pharmacy label on the patch indicated: Lidocaine 5% patch. Apply one patch and remove once daily. On for 12 hours and off for 12 hours; lower back pain. At 9:18 a.m., the surveyor observed ULP-E removing a lidocaine 5% patch from R1's left knee, then applying the new lidocaine patch. ULP-E stated the evening shift should have removed the old patch and didn't. ULP-E further stated they used to apply the patch to R1's lower back, though since R1's surgery to her left leg, R1 had requested staff apply it to her left knee instead. ULP-E stated staff place the patch wherever R1 wants it, and the nurse is aware of this. On March 3, 2026, at 9:46 a.m., clinical nurse supervisor (CNS)-C stated R1's lidocaine patch was ordered for her lower back and had just observed the patch on R1's left knee. CNS-C further stated being unaware staff had been putting the patch on R1's left knee rather than her lower back and should have notified CNS-C of R1's request. R4 R4's diagnoses included hypertention.	02320		

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02320	Continued From page 45 R4's Resident Service Plan signed September 16, 2024, included medication administration. R4's MAR dated March 2026, included the following order: Earwax Removal Drops 6.5% Instill five drops into each ear every week on Tuesdays. On March 3, 2026, at 9:24 a.m., the surveyor observed ULP-E setting up and administering R4's morning medications including the earwax removal drops. R4 was seated in his wheelchair in the living room area. ULP-E directed R4 to tilt his head to the right; ULP-E then grasped R4's left earlobe, pulled up and back, and administered the ear drops. ULP-E then directed R4 to keep his head tilted while she quickly obtained a paper towel. ULP-E gave the paper towel to R4 and directed the resident to cover his left ear with the paper towel; ULP-E then directed R4 to tilt his head to the left. ULP-E then administered the eardrops into R4's right ear. Once the drops had been administered, R4 then moved his head into the upright position. ULP-E did not direct R4 to keep his head tilted for a period of time to ensure effectiveness, nor wait to administer to the other ear. ULP-E's competency testing sheet titled, Medication Protocol for Ear Drops, signed by a registered nurse (RN) on August 25, 2024, included the following instructions: 8. Position client correctly 9. Compare the medication with medication profile 10. Pull ear up and back 11. Administer correct number of drops in correct ear: Avoid contact of ear with dropper 12. Instruct client to remain in position for	02320		

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02320	Continued From page 46 approximately 5 minutes 13. Repeat for other ear if ordered On March 3, 2026, at 9:50 a.m., CNS-C stated she would expect staff to administer ear drops into one ear and have the resident remain with their head tilted to the side for approximately five minutes before applying drops to the other ear; then repeat the procedure, "Otherwise the medication will just run out". The licensee's undated, Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy indicated: Unlicensed personnel that satisfy the training requirements, have been determined competent to follow the procedures and have been delegated the responsibility by the RN, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of inhalant or nebulizer, gastric tube, insulin injections or topically by following the RN's written instructions for administering the medications to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

NG and NG Services Group LLC
14311 Aspen Avenue
Rosemount, MN 55068
Dakota County
Parcel:

Phone:

License Info

License: HFID 41368

Risk:
License:
Expires on:
CFPM: Eucharia I. Unamba
CFPM #: FM105401; Exp: 12/21/2026

Inspection Info

Report Number: F1043261077
Inspection Type: Full - Single
Date: 3/3/2026 Time: 1:01:39 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

! 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: NO ILLNESS LOG IN USE. ADVISED STAFF TO PROVIDE AND RECORD ILLNESSES FOR STAFF WHO GOES HOME SICK OR CALLS IN SICK. LOG PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 3/3/2026 Originally Issued On: 3/3/2026

New Order: 2-500 Cleanup of Vomiting and Diarrheal Events

2-501.11 *Priority Level: Priority 2 CFP#: 5*

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

COMMENT: NO CLEAN UP PROCEDURES OR SPILL KIT AVAILABLE. ADVISED STAFF TO PROVIDE AT LEAST ONE OPTION. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 3/3/2026 Originally Issued On: 3/3/2026

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

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

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

COMMENT: BOX OF RAW SHELL EGGS STORED ON SHELF ABOVE READY-TO-EAT FOODS (CHEESE, HOT DOG, CHICKEN, ETC.) IN KITCHEN FRIDGE. ADVISED STAFF TO STORE RAW FOODS AT BOTTOM. CORRECTED ONSITE. COMPLY WITH ABOVE RULE.

Comply By: 3/3/2026 Originally Issued On: 3/3/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A *Priority Level: Priority 3 CFP#: 39*

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

COMMENT: RICE, CHIPS, CRACKERS, ETC. STORED ON FLOOR OF PANTRY CLOSET. ADVISED STAFF TO RELOCATE FOODS TO AN APPROVED HEIGHT. COMPLY WITH ABOVE RULE.

Comply By: 3/3/2026 Originally Issued On: 3/3/2026

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: FACILITY USES CHLORINE FOR SANITIZER. SANI SPRAY BOTTLE MEASURED ABOVE 200 PPM. ADVISED STAFF TO MAINTAIN BETWEEN 50-200 PPM. CORRECTED ONSITE TO 200 PPM. COMPLY WITH ABOVE RULE.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

Food & Beverage General Comment

Inspection was completed with Wendy Buckholz as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, illness policy, sanitizer use, ware washing, temperature control, same day food service, cleaning, vomit/fecal procedures, test kits, food storage, and food handling procedures.

TEMPERATURE (F)
FRIDGE: CHEESE 40, MILK 40, HALF & HALF 41, BUTTER 40

UTENSIL SURFACE TEMPERATURE (F)
DISH MACHINE: DISH MACHINE IS TESTED MONTHLY BY FACILITY. LAST RECORDED TEST WAS ON 3/1 AND MEASURED AT LEAST 180F.

CHLORINE (PPM)
SANI SPRAY BOTTLE: +200* (CORRECTED TO 200)

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations.

This facility has a residential kitchen with residential equipment, wooden cabinetry, laminated flooring, smooth walls, and textured ceilings. Facility has a NSF dish machine. Conditions of equipment and physical facility will be monitored during future inspections – must be brought up to code if at such time they are found to be a concern or risk of contamination.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

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 F1043261077 from 3/3/2026

Eucharia I. Unamba
CFPM

Blia Lor,
Public Health Sanitarian 1
651-355-0641
blia.lor@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41368015-0	**Date:** MARCH 3, 2026
Facility Name: NG & NG SERVICES GROUP LLC	
Facility Address: 14311 ASPEN AVENUE, ROSEMOUNT, MN 55068	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. A means of egress shall be free from obstructions that would prevent its use. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: In occupied resident bedrooms one and six, access to the egress windows was obstructed by the storage of personal items in front of these windows.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: An extension cord was used to supply power to a refrigeration unit in the mechanical room.

4. Occupancy separation shall be provided in Group I and Group R occupancies. Existing wood lath and plaster in good condition or ½ inch gypsum wallboard is acceptable where one hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

   Comments: In the attached garage, the ceiling access panel was not securely installed, there were gaps around the panel. The garage ceiling shall be maintained free of holes and sealed to prevent the passage of smoke or fire.

5. A working space of not less than 30 inches in width, 36 inches in depth and 78 inches in height shall be provided in front of electrical service equipment. Where the equipment is wider than 30 inches, the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

Comments: In the attached garage, the space in front of the electrical panel was used improperly for storage.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - In occupied resident room two, there was a hole at the base of the door.
   - In the main floor hallway, there was a hole at the base of the wall outside the residents' rooms.
   - On the exterior of the building, there was a large accumulation of dust on a vent cover.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire safety and evacuation (FSEP) floor plans displayed in the building did not accurately identify the location and number of resident bedrooms. There were two different sets of floor plans. The multi-colored floor plans, dated January 3, 2025, identified a storage room in the basement and did not include resident bedroom numbers. The undated green floor plans identified the storage room as bedroom five. Accurate FSEP floor plans shall be maintained. Resident bedroom numbers need to be included on the FSEP floor plan and used with the numbers installed at the resident bedroom doors to provide efficient communication for exiting in the event of a fire or similar emergency.

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

   Comments:

- The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.
- In the emergency binder, there were procedures and a floor plan for a building with a different address and layout.
- The FSEP inaccurately referenced pull fire alarms and was created using third party templates.
- The individual resident fire escape plans direct employees to use the attached garage as an emergency exit. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard space.
- The individual resident fire escape plan for the occupied basement bedroom inappropriately instructed employees that this resident was to remain downstairs and exit through the nearest safe door. There was not a door downstairs exiting to the outside from this building.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans at the time of hire and at least twice per year. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for employee fire safety and evacuation plan training completed at the time of hire from administrator/unlicensed personnel (A/ULP)-B. A/ULP-B stated all employees had been trained but this training was not documented. A/ULP-B explained the house manager was currently working on creating forms to record new hire training.

4. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for evacuation drills completed between March 2025 and March 2026, from the licensee. Record review of fire drill logs indicated drills were not completed during the night shift in the past year. Additionally, the simulated conditions were not recorded on the fire drill reports.