



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 6, 2026

Licensee
Our Caring Hands LLP
9220 207th Street West
Lakeville, MN 55044

RE: Project Number(s) SL34952016-0

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34952	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER OUR CARING HANDS LLP			STREET ADDRESS, CITY, STATE, ZIP CODE 9220 207TH STREET WEST LAKEVILLE, MN 55044		
(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: SL34952016-0 On June 1, 2026, through June 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 four resident(s); four receiving services under the 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan that included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility, and failed to have a daily work schedule posted in a central location, in accordance with Minnesota Administrative Rule 4659.0180, accessible to staff, residents, volunteers, and the public as required. This had the potential to affect	0 470			

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0 470	Continued From page 2 all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 1, 2026, at 3:40 p.m. during a facility tour, no staff schedule posting was observed. At this time, clinical nurse supervisor (CNS)-A stated they had been using a white board, but currently it was not in use. The licensee's Staffing Plan included information about work schedule, recording of time worked, work attendance and other employee related content. The document did not include the following required content: (11) A plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;	0 470			

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0 470	Continued From page 3 (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions. On June 2, 2028, at 12:14 p.m., CNS-A stated he was unaware of the required content of a staffing plan, and the document provided was all they had. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the	0 480			

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0 480	Continued From page 4 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food 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.	0 480			

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0 480	Continued From page 5 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 June 2, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary	0 485			

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0 485	Continued From page 6 allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Resident Contract for Assisted Living included the following information: This Assisted Living Facility offers all of the following (included in the Month Base Fee): - At least three meals daily with snacks	0 485			

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0 485	Continued From page 7 available seven (7) days per week The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee and lacked the option to opt out of the meal plan. On June 2, 2026, at 1:30 p.m., assisted living director in residency (ALDIR)-B stated the contract was the one signed by all the residents. ALDIR-B stated the meals were included in the base monthly fee and residents were not able to opt out of the meal plan. The licensee's undated, Assisted Living Contracts policy included "The minimum requirements for assisted living require that three (3) meals and snacks must be made available and state that the facility cannot require a resident to include and pay for meals in their contract." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult	0 550			

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0 550	Continued From page 8 Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have all the required contact information in the posted grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 1, 2026, at 3:40 p.m., the surveyor observed the grievance posting. The posting included the house manager (HM-F) and their phone number, but did not include the email contact information as required. The licensee's Resident Complaints and Resolution posting dated February 1, 2026, included "Complaints can be made to" and included HM-F, their phone number and address. The document did not contain the HM-F's email contact information as required.	0 550			

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0 550	Continued From page 9 On June 1, 2026, at 3:40 p.m., clinical nurse supervisor (CNS)-A stated he was unaware the email for HM-F had to be included in the posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on 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) which included completion of a chest x-ray after a positive blood test for one of two employees (unlicensed personnel (ULP)-D).	0 660			

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0 660	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On June 2, 2026, at 6:00 a.m., the surveyor arrived onsite and ULP-D was working alone in the home. ULP-D stated during the night shift, she turns and repositions residents, empties catheters, and completes other cares as needed. ULP-D stated she had been with the company 2.5 years and began at another home, but now works at this one. ULP-D was hired on July 17, 2024, and provided direct care services to the licensee's residents. ULP-D's employee record included a TB screening completed on July 17, 2024, and a TB blood test completed on July 23, 2024, which indicated positive results. ULP-D's record lacked evidence of a chest x-ray confirming no active TB disease. On June 3, 2026, at 11:02 a.m., clinical nurse supervisor (CNS)-B stated ULP-D should have had TB testing completed prior to contact with the facility's residents. The licensee's undated, Tuberculosis Screening policy included: "1. The health screening will be completed by a	0 660			

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0 660	Continued From page 11 licensed professional before resident contact. Health screening will occur after a conditional offer of employment is made. Repeat testing will be required if deemed necessary by the health care professional for individuals with signs of communicable disease. The nurse manager/designee will be responsible for assuring testing is completed and for any necessary follow-up. This will include any necessary training of supervisors and employees. 2. For all employees, volunteers or contract personnel providing direct resident care, there shall be evidence of baseline TB screening consisting of two components: a. Assessing for current symptoms of active TB disease, (see Baseline TB Screening Tool in Sample Forms) and b. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test. If the employee has proof of a TB blood test or negative Chest X-ray within 90 days of employment, it does not have to be repeated at the time of hire." "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, indicated the following: "Before the HCW has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and 4. Medical evaluation to rule out a diagnosis of	0 660			

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0 660	Continued From page 12 infectious TB disease." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 680			

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0 680	Continued From page 13 licensee failed to maintain a written emergency preparedness plan (EPP), updated annually, with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee provided a three ring binder identified as the facility's Emergency Preparedness Manual. The licensee's emergency preparedness plan was last reviewed July 29, 2024, and lacked evidence of the following required content: - policy to address emerging infectious disease - quarterly review of missing person plan - identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care. - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority. - arrangements/contracts to re-establish utility services; - all hazards approach with categorized probable risks/hazards by likelihood of occurrence; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - process for cooperation and collaboration with local, tribal, regional, State and Federal	0 680			

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0 680	Continued From page 14 emergency program; - policy and procedure to address food, water, medical supplies and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - policy and procedure to address alternate sources of energy to maintain: temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal; - communication plan that included a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care, a means, in event of evacuation, to release resident information as permitted and a means of providing information about general condition/ location of residents under the facility's care as permitted; - policy and procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - emergency prep testing twice a year; and - Missing Resident Policy dated July 20, 2021, failed to be reviewed quarterly as required. On June 3, 2026, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated the emergency preparedness plan did not include the above information. In addition, CNS-A stated they were unaware the missing person plan was to be updated quarterly. The licensee did not have memorandums of understanding developed. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for three of three residents (R2, R3, R4). 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 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: R2, R3, and R4's medication administration records (MAR) dated May 2026, included initials in the boxes to indicate if medications were administered and on the back of the page included initials, full signature, and title. The MAR was only authenticated by clinical nurse supervisor (CNS)-A. None of the the pages included the initials for the unlicensed personnel (ULP) who administered the medications. On June 3, 2026, at 2:44 p.m., CNS-A stated he was unaware the staff were required to document their name, title, initials.	0 690			

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0 690	Continued From page 16 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	0 730			

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0 730	Continued From page 17 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 observation, interview, and record review, the licensee failed to document services provided as identified on the service plan for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 On June 2, 2026, at 7:00 a.m. the surveyor observed unlicensed personnel (ULP)-E administering medications to R2. During this time, the surveyor observed a document titled,	0 730			

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0 730	Continued From page 18 "Resident Care Schedules for Daily Living Activities" for R2 dated May 2024, located in the medication administration binder, and it indicated R2's services included the following: Day shift - washing and dressing assistance, medication administration, meals, incontinence care as needed, catheter care with dressing change, transfer with two assist, bathing, feeding assistance, showers twice a week, Night shift - assist to get ready for bed, change incontinent products as needed, medication administration, catheter care, resident prefers to sleep in wheelchair. R2's medication administration record (MAR) dated May 2026, included catheter cares twice daily. On June 2, 2026, 7:27 a.m., the surveyor observed ULP-E and ULP-G completing a.m. personal cares. They used a Hoyer lift (full body mechanical lift) to transfer R2 from his wheelchair into his bed. completed stoma cares around the urostomy and emptied the catheter, changed R2's incontinent brief, completed a bed bath, dressed R2, assisted to brush teeth, and transferred him back to his wheelchair using a Hoyer lift. On June 2, 2026, at 12:14 p.m., the surveyor observed ULP-E providing feeding assistance to R2. R2's service plan dated January 21, 2026, indicated R2's services included medication set-up, medication administration, treatments as ordered, bathing assistance, dressing assistance, grooming assistance, continence care, positioning, and transfers by a Hoyer lift. R2's Unlicensed Personal (ULP) Flow Charting	0 730			

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0 730	Continued From page 19 dated May 18, 2026, through June 3, 2026, included columns for each day of the week, and rows which had services listed and boxes for staff to initial. The services listed in the document included - day shift - oral care, shower, toileting, incontinent care (yes/no), percentage of food eaten for each meal - night shift - oral care, toileting, incontinent care (yes/no), repositioned number (staff documented as not applicable), and hours slept The document did not include documentation of Hoyer transfer, feeding assistance, dressing, grooming, and staff were documenting the repositioning as not applicable even though it was on the Service Plan and the ULP Flow Charting. On June 3, 2026, at 2:44 p.m., clinical nurse supervisor (CNS)-A stated the ULP Flow Charting document was the same used for all residents and was the only documentation of services the staff filled out. CNS-A further stated he was unaware all services on the service plan, including Hoyer transfer assistance, feeding assistance, dressing and grooming, needed to be documented. The licensee's undated, Resident Records policy indicated the record would include documentation of service as identified on the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 20 (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, interview, and record review, 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			

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0 810	Continued From page 22 Based on observation, interview, and record review, 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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced	0 970			

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0 970	Continued From page 23 by: Based on interview and record review, the licensee failed to ensure the assisted living did not require all residents to waive liability for health, safety, or personal property. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Resident Contract for Assisted Living included the following information: "24.PROVISIONS RELATED TO LIABILITY A. Damage of Injury to Resident of Resident's Property. We are not responsible for any damage or injury suffered by you, your property, your guests or their property that was not caused by us. We strongly recommend that Resident obtain renter's insurance at an appropriate level to insure against loss of Resident's personal property, as well as related incidental and consequential damages, or such other or additional insurance as Resident considers necessary to protect against injuries and property damage. Our insurance may not cover the loss of your personal property and the incidental and consequential damages arising from the loss of such property. Your personal property includes but is not limited to dentures, glasses and hearing aids." On June 2, 2026, at 1:30 p.m., assisted living director in residency (ALDIR)-B stated the	0 970			

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0 970	Continued From page 24 contract was the same contract signed by all the residents. ALDIR-B stated she was unaware a waiver of liability could not be included in a contract. The licensee's undated, Assisted Living Contracts policy included "The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful or unenforceable under state or federal law." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
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	01060			

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01060	Continued From page 25 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with all the required content to the resident, legal representative, designated representative, and ombudsman for an emergency relocation 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	01060			

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01060	Continued From page 26 has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's Nursing Notes included the following: - On March 14, 2026, R1 was transferred to the emergency room, admitted, had a procedure and returned on March 18, 2026; and - On April 17, 2026, R1 was sent to the ER and on April 20, 2026 the facility was notified R1 passed away at the hospital. R1's record contained a notice of Transfer or Discharge dated March 14, 2026, and March 17, 2026. The documents did not include the following required content: - 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 and the Office of Ombudsman for Mental Health and Developmental Disabilities; - 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 - 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. In addition R1's record lacked evidence R1, their responsible party and their case manager had been notified as soon as practicable On June 2, 2026, at 12:14 p.m., clinical nurse supervisor (CNS)-A stated he was unaware of the	01060			

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01060	Continued From page 27 required content of the emergency transfer notification and he was unaware notifications had to be provided in writing for an emergency transfer. The licensee's undated, Assisted Living Contract Terminations policy included a section titled "Emergency Relocation" which included the following information: 2. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: a. 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 c. Contact information for the Office of Ombudsman for Long-Term Care d. 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 e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 1440 .54; the facility must provide contact information for the agency to which the resident may submit an appeal f. The notice of emergency relocation must be delivered as soon as practicable to: 1. The resident, legal representative, and designated representative 2. for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and 3. the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.	01060			

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01060	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=D	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 in affiliation with the assisted living license for one of one employee (assisted living director in residency (ALDIR)-B). This had the potential to affect all residents living in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290			

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01290	Continued From page 29 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: ALDIR-B was hired January 2026, and provided direct care and resident oversight for the licensee's residents. NETStudy 2.0 indicated ALDIR-B had a background study clearance affiliated to health facility identification (HFID) 25395, a sister facility owned by the same person. ALDIR-B did not have an active background study for this license (HFID 34952). On June 2, 2026, at 2:08 p.m., the surveyor spoke with the sensitive information person (SIP) by phone who stated he had access to all four homes owned by the company and he was bale to see ALDIR-A was affiliated to HFID 25395. The licensee's undated, Background Studies policy included: 1. Each facility employee/volunteer or contractor who will provide direct care to residents must have a background study completed. The forms will be completed at the time of hire. If the person fails to provide the information necessary to complete the background study, their application for direct care employment will not be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	01290			

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01290	Continued From page 30 days	01290			
01650 SS=D	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 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of one	01650			

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01650	Continued From page 31 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). The findings include: On June 2, 2026, at 7:00 a.m. the surveyor observed a Resident Care Schedules for Daily Living Activities document for R2 dated May 2024, located in the medication administration binder, and it indicated R2's services included the following: Day shift - washing and dressing assistance, medication administration, meals, incontinence care as needed, catheter care with dressing change, transfer with two assist, bathing, feeding assistance, showers twice a week; Night shift - assist to get ready for bed, change incontinent products as needed, medication administration, catheter care, resident prefers to sleep in wheelchair. On June 2, 2026, at 12:14 p.m., the surveyor observed ULP-E providing feeding assistance to R2. R2's service plan dated January 21, 2026, indicated R2's services included medication set-up, medication administration, treatments as ordered, bathing assistance, dressing assistance, grooming assistance, continence care, positioning, and transfers by hooyer lift. The	01650			

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01650	Continued From page 32 service plan did not include feeding assistance. R2's Unlicensed Personal (ULP) Flow Charting dated May 18, 2026, through June 3, 2026, included columns for each day of the week, and rows which had services listed and boxes for staff to initial. The services listed in the document included: - day shift - oral care, shower, toileting, incontinent care (yes/no), percentage of food eaten for each meal; - night shift - oral care, toileting, incontinent care (yes/no), repositioned number (staff documented as not applicable), and hours slept. The document did not include documentation of Hoyer transfer, feeding assistance, dressing, grooming, and staff were documenting the repositioning as not applicable even though it was on the Service Plan and the ULP Flow Charting. On June 3, 2026, at 12:03 p.m., clinical nurse supervisor (CNS)-A stated he was unaware feeding assistance needed to be included on the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750			

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01750	Continued From page 33 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) was properly trained in administration of insulin according to manufacturer recommendations and accepted standards of care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 2, 2026, at 10:04 a.m., the surveyor observed ULP-E assisting R3 with insulin administration. ULP-E removed the pen cap of the Humalog insulin and placed a pen needle onto the pen. ULP-E then dialed the dose and gave the insulin pen to R3. R3 injected the insulin and immediately removed it from the skin. ULP-E did not clean the rubber stopper prior to putting on the pen needle, did not prime the pen, did not clean R3's skin prior to administration and did not cue R3 to hold the needle in the skin for the appropriate amount of time after the injections.	01750			

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01750	Continued From page 34 ULP-E then repeated the same process with R3's Lantus insulin. On June 3, 2026, at 1:15 p.m., clinical nurse supervisor (CNS)-A stated staff were not trained to clean the rubber stopper or prime the pen; however, staff should cue the resident to use alcohol to clean skin and hold the needle in the skin for the appropriate amount of time after injection per the manufacturer instructions. Humalog prescribing information dated May 2025, included priming the insulin pen with 2 units, cleaning the skin prior to injection, and after injection continue to hold the Dose Knob in and slowly count to 5 before removing the needle from the skin. Lantus prescribing information dated November 2018, included wipe the rubber seal with alcohol prior to putting the needle on the pen, prime the pen with 2 units, and after administering the dose slowly count to 10 before removing the needle from the skin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	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	01760			

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01760	Continued From page 35 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 prescribed for three of three residents (R2, R3, R4). 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: R2 On June 2, 2026, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-E setting up R2's medications. ULP-E removed a bottle of Miralax and filled the cap approximately 1/2 way and put it into a glass of water and administered it to R2. On June 2, 2026, at 7:27 a.m., ULP-G was completing R2's urostomy stoma cares. ULP-G removed the soiled dressing, cleaned the site, applied triple antibiotic ointment and placed a	01760			

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01760	Continued From page 36 clean dressing. R2's medication administration record (MAR) for May 2026, included: - Miralax 17 grams (measure with marking inside cap) mix in 4-8 ounces of water and give daily. Although, the 17 gram measurement is the top of the white insert in the cap, 1/2 of that is what ULP-E administered. - Catheter care twice daily. Cleanse insertion site using an alcohol swab. Change dressing once daily. The catheter care did not include use of an ointment. R2's physician orders dated May 7, 2026, included: - Miralax 17 grams mix in 4-8 ounces of water and give daily. - bacitracin apply a pea size amount to the supra pubic catheter site. Although the order was for bacitracin ointment, triple antibiotic ointment was used. R3 On June 2, 2026, at 10:04 a.m., the surveyor observed ULP-E administering medications to R3. R3's medications were pre set-up by the nurse. ULP-E dumped them into a medication cup and administered them to R3. R3's MAR dated May 2026, included orders for cetirizine, furosemide, butrans, oxycodone, lorazepam, methenamine, microguard powder, and Senna S, but none of these were signed by CNS-A as being set up or signed off by staff as administered. R3's physician orders signed May 26, 2026, included orders for cetirizine, furosemide, butrans, oxycodone, lorazepam, methenamine,	01760			

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01760	Continued From page 37 microguard powder, and Senna S. R4 On June 2, 2026, at 8:45 a.m., the surveyor observed ULP-E administering two pills to R4. The surveyor observed many medications listed on the MAR, but they had not been signed off this month. R4's MAR dated May 2026, included orders for calcium, vitamin B-12, Vitamin D-3, Desenex, aspirin, ferrous gluconate, and Vitamin C but none of these were signed off by CNS-A as being set up or by the staff as administered. R4's physician visit note dated April 14, 2026, indicated medications were reconciled by the provider but did not list his current medications. On June 3, 2026, at 1:58 p.m., clinical nurse supervisor (CNS)-A stated some of the orders were old orders and no longer had refills or were for a limited time. The pharmacy makes the medication sheets based on the orders they have. So if the pharmacy has old orders in the system, it pulls in and prints on the MAR. CNS-A stated the MAR should be accurate to what the residents are taking. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880			

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01880	Continued From page 38 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 securely locked permitting only authorized personnel to have access. This had the potential to affect all residents within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 2, 2026, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-E unlock the medication cabinet, remove R4's medications, set up the morning medications for administration, and went to R4's room to administer the medications, leaving the medication cabinet unlocked and not within ULP-E's sight. R2 was in his room right next to the kitchen and is able to see the medication cabinet from where he was sitting. After attempting administration, and leaving medications at bedside, ULP-E returned to the medication cabinet and locked it. On June 3, 2026, at 12:03 p.m., clinical nurse supervisor (CNS)-C stated staff should have locked the cabinet prior to leaving the room. All	01880			

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01880	Continued From page 39 medications should be securely stored in the locked medication cabinet and should not have been left unlocked. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled with the date opened for time sensitive medications and failed to ensure medications were maintained bearing the original prescription label for three of three residents (R2, R3, R4). 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).	01890			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 40 The findings include: On June 1, 2026, at 3:22 p.m., the surveyor and clinical nurse supervisor (CNS)-C reviewed the facility's medication cabinet and noted the following: - R2 had a single Lovenox (blood thinner) injection without a pharmacy label; - R3 had a fluticasone HFA inhaler without a label, open date or the box; and - R3 had Lantus insulin pen and a Humalog insulin pen without pharmacy labels. On June 1, 2026, at 3:22 p.m., CNS-C stated all medications should have a pharmacy label, and any time sensitive medications should have an opened date. Fluticasone's prescribing information dated November 2010, included "Do not use the inhaler after the expiration date, which is on the packaging it comes in." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current	01940			

Minnesota Department of Health

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01940	Continued From page 41 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a written statement of the treatment on the service plan for one of one residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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).	01940			

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01940	Continued From page 42 The findings include: On June 2, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E was observed completing personal cares. ULP-E filled a 60 milliliter (ml) syringe with saline, separate the urinary catheter from the catheter collection bag, cleansed the ports, pushed in the saline, cleansed the ports again, and reconnected the catheter to the drainage bag. R2's Resident Care Schedules for Daily Living Activities dated May 2024, located in the medication administration binder, indicated R2's services included catheter care. There was no specific instructions for the catheter flush. R2's May 2026, medication administration record (MAR) included gentamicin 240 milligram/Liter (mg/L) bladder irrigation. Irrigate 50-100 ml into the bladder three times a week, on off days irrigate 60 ml normal saline. This was signed off by staff three days a week. The MAR did not include specific instructions for the administration, possible side effects or adverse reactions, or what to report to the nurse. R2's physician orders dated May 7, 2026, included gentamicin 240 mg/L bladder irrigate three times weekly with 60-120 ml and sodium chloride irrigation 0.9% both nares (nostrils) [sic]. R2's Medication Management Plan dated January 20, 2026, indicated medication administration tasks that could be delegated to unlicensed personnel included oral medications and subcutaneous medications. The medication plan did not include medications administered via the urinary catheter.	01940			

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01940	Continued From page 43 R2's service plan dated January 21, 2026, indicated R2's services included medication set-up, medication administration, treatments as ordered, bathing assistance, dressing assistance, grooming assistance, continence care, positioning, and transfers by Hoyer lift. R2's service plan did not include the catheter cares with the catheter flush. On June 3, 2026, at 12:03 p.m., clinical nurse supervisor (CNS)-A stated he was unaware the catheter flush was a treatment and needed to be included on the service plan. The licensee's undated, Treatment and Therapy Management Plan indicated: "I. When the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided b. Documentation of specific instructions that relate to providing the treatment or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented f. Frequency of supervision of personnel providing the delegated treatment or therapy services g. Verification by the registered nurse that services are administered as prescribed and	01940			

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01940	Continued From page 44 monitoring of treatment or therapy to prevent complications or adverse reactions h. The treatment or therapy plan will be updated when there are changes i. The Facility may provide Care Plans and other supportive documents to communicate the plan to caregivers by referencing them on the individualized plan. 1. Treatments and therapies that are prescribed for the resident will be administered by a nurse or other health professional authorized to provide the therapy. 2. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility will ensure that the registered nurse or authorized licensed health professional has: a. Instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedure b. Specified in writing detailed instructions for each resident and documented the instructions in the resident's record c. Communicated with the unlicensed personnel about the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be	01950			

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01950	Continued From page 45 delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to specify in writing, specific instructions and failed to document a treatment for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On June 2, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E completing personal cares. ULP-E filled a 60 milliliter (ml) syringe with saline, separate the urinary catheter from the catheter collection bag,	01950			

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01950	Continued From page 46 cleansed the ports, pushed in the saline, cleansed the ports again and reconnected the catheter to the drainage bag. R2's Resident Care Schedules for Daily Living Activities dated May 2024, located in the medication administration binder, indicated R2's services included catheter care. There was no specific instructions for the catheter flush. R2's May 2026, medication administration record (MAR) included gentamicin 240 milligram/liter (mg/L) bladder irrigation. Irrigate 50-100 ml into the bladder three times a week, on off days irrigate 60 ml normal saline. This was signed off by staff three days a week. The MAR did not include specific instructions for the administration, possible side effects or adverse reactions, or what to report to the nurse. R2's physician orders dated May 7, 2026, included gentamicin 240 mg/L bladder irrigate three times weekly with 60-120 ml and sodium chloride irrigation 0.9% both nares (nostrils) [sic]. R2's service plan dated January 21, 2026, indicated R2's services included medication set-up, medication administration, treatments as ordered, bathing assistance, dressing assistance, grooming assistance, continence care, positioning, and transfers by hoyer lift. R2's service plan did not include the catheter cares or the catheter flush. On June 3, 2026, at 12:03 p.m., clinical nurse supervisor (CNS)-A stated he was unaware the catheter flush needed specific instructions for the staff and have them documented in R2's chart. CNS-A stated he had the saline catheter flush on the same line as the medicated flush and staff	01950			

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01950	Continued From page 47 were signing off the medicated flush but were not signing off the saline flush. The licensee's undated, Treatment and Therapy Management Plan indicated each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have an accurate order with all the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01970			

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01970	Continued From page 48 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: On June 2, 2026, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E completing personal cares. ULP-E filled a 60 milliliter (ml) syringe with saline, separate the urinary catheter from the catheter collection bag, cleansed the ports, pushed in the saline, cleansed the ports again and reconnected the catheter to the drainage bag. R2's May 2026, medication administration record (MAR) included gentamicin 240 milligrams/liter (mg/L) bladder irrigation. Irrigate 50-100 ml into the bladder three times a week, on off days irrigate 60 ml normal saline. This was signed off by staff three days a week. The MAR did not include specific instructions for the administration, possible side effects or adverse reactions, or what to report to the nurse. R2's physician orders dated May 7, 2026, included gentamicin 240 milligrams/liter (mg/L) bladder irrigate three times weekly with 60-120 ml and sodium chloride irrigation 0.9% (normal saline) both nares (nostrils) [sic]. The order did not include the correct route of administration or the amount the staff were to administer with the saline flush. R2's service plan dated January 21, 2026, indicated R2's services included medication set-up, medication administration, treatments as	01970			

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01970	Continued From page 49 ordered, bathing assistance, dressing assistance, grooming assistance, continence care, positioning, and transfers by hooyer lift. R2's service plan did not include the catheter cares or the catheter flush. On June 3, 2026, at 11:02 a.m., clinical nurse supervisor (CNS)-A stated the saline flush order should have been in the chart; additionally, the order is incorrect with "nares" and should have the amount and the correct route in the order. The licensee's undated, Treatment and Therapy Management Plan indicated each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
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:	02320			

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02320	Continued From page 50 Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-D) administered medications according to policy and accepted standards of practice. 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: On June 2, 2026, at 8:45 a.m., the surveyor observed ULP-E administering medications to R4. ULP-E removed pills from a caddy and placed into a medication cup. ULP-E brought the medications to R4's room and left the medications on R4's bedside table. ULP-E did not observe R4 taking the medications. On R4's 90-day assessment dated April 14, 2026, indicated R4 received medication administration and was not to self-administer medications. On June 3, 2026, at 12:03 p.m., clinical nurse supervisor (CNS)-A stated R4 was not to self-administer medications and ULP-E should have stayed with R4 until he took them. On June 2, 2026, at 10:04 a.m., the surveyor observed ULP-E administering medications to R3. ULP-E handed R3 an fluticasone inhaler with a spacer and told her "two puffs." R3 took one puff and ULP-E immediately prompted R3 to "do	02320			

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02320	Continued From page 51 a second puff," which R3 did. ULP-E did not prompt R3 to rinse her mouth after using the inhaler. On June 3, 2026, at 12:03 p.m., CNS-A stated staff are trained to wait one minute between puffs of the inhaler and to rinse their mouth after use. CNS-A stated ULP-E should have prompted R4. No further information 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

Page: 1

Establishment Info

Our Caring Hands LLP
9220 207TH STREET WEST
Lakeville, MN 55044
Dakota County
Parcel:

Phone:

License Info

License: HFID 34952

Risk:
License:
Expires on:
CFPM: Gabriella Nowrang
CFPM #: FM13688; Exp: 6/22/2028

Inspection Info

Report Number: F1004261164
Inspection Type: Full - Single
Date: 6/2/2026 Time: 11:15:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery: Emailed

Previous Order: 2-100 Supervision

2-102.12DMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: **ACTIVE CFPM CERTIFICATE NOT POSTED ON SITE. POST CURRENT CERTIFICATE AND MAINTAIN.**

Comply By: 6/2/2026 Originally Issued On: 6/2/2026

! Previous 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: **RAW SHELL EGGS FOUND STORED OVER READY-TO-EAT ITEMS IN THE KITCHEN REFRIGERATOR. DISCUSSED STORAGE ORDER AND INSTRUCTED STAFF TO MOVE RAW ANIMAL PRODUCTS TO THE LOWEST PORTION OF THE REFRIGERATOR.**

Comply By: 6/2/2026 Originally Issued On: 6/2/2026

Previous Order: 4-200 Equipment Design and Construction

4-204.112A Priority Level: Priority 3 CFP#: 36

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: **NO INTERNAL THERMOMETERS IN THE KITCHEN OR GARAGE REFRIGERATORS. PROVIDE AND MAINTAIN IN THE WARMEST PART OF THE UNIT (NEAR THE DOOR) TO VERIFY THE AMBIENT TEMPERATURE OF THE COLD HOLDING UNITS.**

Comply By: 6/2/2026 Originally Issued On: 6/2/2026

Previous Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT: **NO TEST KIT FOR USE WITH CHLORINE (BLEACH) SANITIZING SOLUTION. PROVIDE AND USE FREQUENTLY.**

Comply By: 6/2/2026 Originally Issued On: 6/2/2026

Previous Order: 6-200 Physical Facility Design and Construction

6-201.11A Priority Level: Priority 3 CFP#: 55

MN Rule 4626.1335A Design, construct, and install floors, floor coverings, walls, wall coverings, and ceilings to be smooth and easily cleanable.

COMMENT: **MULTIPLE FLOOR TILES THROUGHOUT KITCHEN ARE LOOSE. REINSTALL AND MAINTAIN.**

Comply By: 9/2/2026 Originally Issued On: 6/2/2026

! Previous Order: 7-200 Toxic Supplies and Applications7-204.11 *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: CHLORINE CONCENTRATION IN THE KITCHEN SANITIZER SPRAY BOTTLE EXCEEDED 200PPM.

ENSURE A CONCENTRATION OF 50-100PPM IS MAINTAINED FOR SAFE SANITIZING. DISCUSSED DILUTING THE BOTTLE AND USING TEST STRIPS TO VERIFY CONCENTRATION DURING EVERY FILL.

Comply By: 6/2/2026 Originally Issued On: 6/2/2026

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY STACY HAAG.

DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- PREVENTING BAREHAND CONTACT
- SANITIZER USE AND TEST KITS
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- FOOD SERVICE PROCEDURES (SAME-DAY SERVICE)
- PEST CONTROL
- LOGS (COOLER TEMPERATURE, DISH MACHINE, ETC)
- PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE AND WITH THE NURSE EVALUATOR ON SITE AT THE CONCLUSION OF THE INSPECTION.

*FLOORS ARE TILE, WALLS ARE SMOOTH PAINTED DRYWALL, AND CEILING IS "ORANGE PEEL" TEXTURE. COUNTERTOPS ARE SMOOTH SEALED STONE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION (ASIDE FROM FLOOR TILES BEING LOOSE) AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*KITCHEN HAS RESIDENTIAL GRADE EQUIPMENT. ALL FOOD MUST BE PREPARED AND SERVED SAME-DAY.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 F1004261164 from 6/2/2026

Molly Dougherty

Gabriella Nowrang

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Our Caring Hands LLP
Lakeville
County/Group: Dakota County

Inspection Info

Report Number: F1004261164
Inspection Type: Full
Date: 6/2/2026
Time: 11:15:00 AM

Equipment Temperature: **Product/Item/Unit:** ambient temperature; **Temperature Process:** Cold-Holding

Location: Refrigerator (Kitchen) at <40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** chicken salad; **Temperature Process:** Cold-Holding

Location: Refrigerator (Kitchen) at 41 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** ambient temperature; **Temperature Process:** Cold-Holding

Location: Refrigerator (Garage) at <40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Our Caring Hands LLP
Lakeville
County/Group: Dakota County

Inspection Info

Report Number: F1004261164
Inspection Type: Full
Date: 6/2/2026
Time: 11:15:00 AM

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

Location: Kitchen **Equal To** 160 Degrees F.

Comment: *per establishment's irreversible temperature indicator (utensil surface temperature reached at least 160°F)

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34952016-0	Date: 6/2/2026
Facility Name: OUR CARING HANDS LLP	
Facility Address: 9220 207th ST W, Lakeville, MN 55044	

☒ TAG IDENTIFICATION: 0800

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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: Under the basement stairwell storage area, the light fixture was not secure. Unsecure wiring could lead to shock and potential excess heat build up which can cause fires.*
- On the exterior west side of the garage the outlet wasn't attached to the siding. Unsecure wiring could lead to shock and potential excess heat build up which can cause fires.*
- On the concrete front steps of the facility there was a surface area that was no longer smooth, which could cause a potential tripping hazard for staff, residents and visitors.*

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The facility posted evacuation maps only showed the main level and not the entire facility. Exit plan diagrams must be correctly labeled to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

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

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP didn't identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP didn't included standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

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

Comments: Assisted Living Director in Residency (ALDIR)-B provided staff training records from a web-based training site, the training documentation record lacked any training on the facility specific fire safety and evacuation plan

6. 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. [Minn. Stat. 144G.45 subd.2]

Comments: ALDIR-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

7. 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: Surveyor requested evacuation drill documentation from ALDIR-B; provided documentation showed evacuation drills only occurred during the day shift, there were no documented drills for any other shifts.