Electronically Delivered

September 9, 2025

Licensee
Bright Side Healthcare LLC
2613 65th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL38155016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

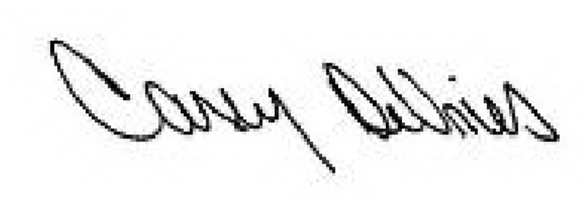
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Carrie.Euerle@state.mn.us
Telephone: 651-242-8846 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38155	A. BUILDING: _____ B. WING _____	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT SIDE HEALTHCARE LLC	2613 65TH AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: SL38155016-0 On July 15, 2025, through July 17, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; five 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.	
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (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 baseline testing and screening within 90 days of hire for one of three employees (unlicensed personnel (ULP)-E). 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:	0 660		

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0 660	Continued From page 2 ULP-E was hired August 12, 2023, to provide direct care services. ULP-E's employee file contained a TB screening form. The form included ULP-E's date of birth. Written in the date the form was completed section was the same date of birth, not the date the form was completed. The TB screening form lacked evidence it was completed within the required 90 days. The employee file lacked any additional TB screenings. On July 15, 2025, at 1:14 p.m. clinical nurse supervisor (CNS)-C stated they were hired into the CNS role on July 8, 2025. CNS-C stated previous clinical nurse supervisor (PCNS)-B left employment from the licensee on July 9, 2025. On July 17, 2025, at 11:06 a.m., ULP-E stated they worked for the licensee on a part-time basis and provided direct care services to residents. On July 17, 2025, at 12:26 p.m., CNS-C stated the TB screening form should have been dated when it was completed. CNS-C stated it was an oversight for not having the correct date on the form. The licensee's undated TB Prevention and Control policy indicated licensee would follow the most current guidelines issued by the Center for Disease Control (CDC). The CDC Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated May 17, 2019, recommended all United States health care personnel should have a completed a TB risk assessment, symptom evaluation, TB testing for tuberculosis, with additional working for TB disease with a positive test results or symptoms	0 660		

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0 660	Continued From page 3 compatible with TB disease. The Minnesota Department of Health Tuberculosis Prevention and Control Program dated July 2013 recommended a TB screening was required for all healthcare workers at date of hire, which consisted of assessment for current symptoms of active TB disease, and assessing TB history. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780		

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0 780	Continued From page 4 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 16, 2025, from 1:30 p.m. to 2:30 p.m., the surveyor toured the facility with house manager (HM)-F. The surveyor asked HM-F to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. The smoke alarms in the following locations did not sound when the test button was pressed: - Bedroom 2, 4, and 5 had hardwired (alarms receiving power from the building electrical	0 780		

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0 780	Continued From page 5 system) smoke alarms that was unplugged. These deficient conditions were visually verified by HM-F accompanying on the tour. HM-F plugged in the disconnected smoke alarm in bedroom 2 and it immediately started beeping to indicate the battery needed to be replaced. HM-F had a staff member replace the battery in the smoke alarm at the time of the survey. There were not enough batteries on site to replace them in bedrooms 4 and 5. The smoke alarms in bedrooms 2, 4, and 5 were not interconnected with the rest of the smoke alarms in the facility once they were plugged back in. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 6 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 a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of three employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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's HFID was 38155. ULP-A's employee file included a background study clearance letter dated December 6, 2021, which was affiliated with the licensee's sister facility HFID 37859. The licensee failed to have a background study clearance for ULP-A affiliated with HFID 38155. The licensee's Staffing Schedule for July indicated ULP-A was scheduled to work 14 shifts between the hours of 11:00 p.m., and 7:00 a.m. On July 16, 2025, at 7:17 a.m., the surveyor observed ULP-A at the facility. ULP-A stated they provided cares, including safety checks and medication administration. ULP-A stated they had	01290		

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01290	Continued From page 7 worked at the facility for over three years and worked 24 hours per week. On July 16, 2025, at 2:00 p.m., licensed assisted living director/owner (LALD/O)-D stated they performed background studies prior to staff working at the facility. LALD/O-D stated they were the owner of both facilities. LALD/O-A stated ULP-A was hired to work at facility HFID 38155 but that may have been an error for completing the background study under the sister facility HFID 37859. The licensee's Department of Health License and Registration Application for HFID 38155 and HFID 37859 indicated LALD/O-A was the owner of each facility at 100 percent (%). The licensee's undated Background Studies policy indicated each staff member was required to have a cleared background study before providing cares to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	01470		

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01470	Continued From page 8 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01470		

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01470	Continued From page 9 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-A, ULP-E, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A began employment on December 6, 2021, and began to provide direct care and services to residents. ULP-A's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following:	01470		

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01470	Continued From page 10 - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license, and; - principles of person-centered planning/service delivery. ULP-E ULP-E began employment on August 12, 2023, and began to provide direct care and services to residents. ULP-E's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: - handling emergencies and using emergency services; - handing of resident complaints, reporting of complaints, where to report, and; - orientation to each specific resident and services provided. ULP-G ULP-G began employment on December 21, 2021, and began to provide direct care and services to residents. ULP-G's employee record lacked evidence of orientation to assisted living regulations	01470		

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01470	Continued From page 11 (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following: - review of provider's policies and procedures, and; - handling emergencies and using emergency services. On July 15, 2025, at 1:14 p.m. clinical nurse supervisor (CNS)-C stated they were hired into the CNS role on July 8, 2025. CNS-C stated the previous clinical nurse supervisor (PCNS)-B left employment from the licensee on July 9, 2025. On July 17, 2025, at 12:01 p.m. licensed assisted living director (LALD)-D stated PCNS-B was responsible for the training. LALD-D stated they were unaware there was missing training, and it was an oversight for the training not being completed. The licensee's undated All Staff HRM-5.0 policy indicated unlicensed personnel would receive orientation and training on topics required by the Minnesota Statutes and rules for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500		

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	38155	A. BUILDING: _____ B. WING _____	07/17/2025

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01500	Continued From page 12 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01500		

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01500	Continued From page 13 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-A, ULP-E, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A began employment on December 6, 2021, and began to provide direct care and services to residents. ULP-A's employee record lacked the following training to be completed within the last 12 months:	01500		

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01500	Continued From page 14 - infection control techniques and; - principles of person-centered planning/service delivery. ULP-E ULP-E began employment on August 12, 2023, and began to provide direct care and services to residents. ULP-E's employee record lacked the following training to be completed within the last 12 months: - infection control techniques and; - principles of person-centered planning/service delivery. ULP-G ULP-G began employment on December 21, 2021, and began to provide direct care and services to residents. ULP-G's employee record lacked the following training to be completed within the last 12 months: - infection control techniques, and; - principles of person-centered planning/service delivery. On July 15, 2025, at 1:14 p.m., clinical nurse supervisor (CNS)-C stated they were hired into the CNS role on July 8, 2025. CNS-C stated previous clinical nurse supervisor (PCNS)-B left employment from the licensee on July 9, 2025. On July 17, 2025, at 12:01 p.m. licensed assisted living director (LALD)-D stated PCNS-B was responsible for the training. LALD-D stated they were unaware there was missing training, and it was an oversight for the training not being completed.	01500		

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01500	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under	01530		

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01530	Continued From page 16 paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for three of three employees (unlicensed personnel (ULP)-A, ULP-E, ULP-G). 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: ULP-A ULP-A began employment on December 6, 2021, and began to provide direct care and services to residents. The licensee's Staffing Schedule for July 2025 indicated ULP-A was scheduled to work 14 shifts	01530		

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01530	Continued From page 17 between the hours of 11:00 p.m., and 7:00 a.m. On July 16, 2025, at 7:17 a.m., the surveyor observed ULP-A at the facility. ULP-A stated they provided cares, including safety checks and medications. ULP-A stated they had worked at the facility for over three years and worked 24 hours per week. ULP-A's employee file lacked the following training: - required eight hours of dementia training, and; - two hours of mental illness and de-escalation training. ULP-E ULP-E began employment on August 12, 2023, and began to provide direct care and services to residents. The licensee's Staffing Schedule for July 2025 indicated ULP-E was scheduled to work 14 shifts between the hours of 11:00 p.m., and 7:00 a.m. On July 17, 2025, at 11:06 a.m., ULP-E stated they provided direct care services to residents. ULP-E stated they worked part time for the licensee, and they worked the weekend shifts which were eight hours per shift. ULP-E's employee file lacked the following training: - required eight hours of dementia training, and; - two hours of mental illness and de-escalation training. ULP-G ULP-G began employment on December 21, 2021, and began to provide direct care and services to residents.	01530		

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01530	Continued From page 18 The licensee's Staffing Schedule for July 2025 indicated ULP-G was scheduled to work 22 shifts between the hours of 11:00 p.m., and 7:00 a.m., with a total number of hours of 176. ULP-G's employee file lacked the following training: - required eight hours of dementia training, and; - two hours of mental illness and de-escalation training. On July 15, 2025, at 1:14 p.m., clinical nurse supervisor (CNS)-C stated they were hired into the CNS role on July 8, 2025. CNS-C stated previous clinical nurse supervisor (PCNS)-B left employment from the licensee on July 9, 2025. On July 17, 2025, at 12:01 p.m. licensed assisted living director (LALD)-D stated PCNS-B was responsible for the training. LALD-D stated they were unaware there was missing training, and it was an oversight for the training not being completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective	01620		

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01620	Continued From page 19 resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	01620		

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01620	Continued From page 20 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 90 calendar days for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on October 1, 2022, and began receiving assisted living services. R3's Service Plan dated July 10, 2025, indicated R3 received assistance with housekeeping, laundry, grooming reminders, bathing, mediation, and transportation. R3's diagnoses included sickle cell anemia (a blood disorder where the red blood cells are misshaped), and depression. R3's record included Nurse Assessment dated March 10, 2025; the next 90-day assessment should have been completed by June 8, 2025, however the next assessment was completed on	01620		

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01620	Continued From page 21 June 11, 2025. The assessment was three days late. On July 15, 2025, at 1:14 p.m., clinical nurse supervisor (CNS)-C stated they were hired into the CNS role on July 8, 2025. CNS-C stated previous clinical nurse supervisor (PCNS)-B left employment from the licensee on July 9, 2025. On July 15, 2025, at 2:27 p.m., CNS-C stated they were responsible for the assessments for residents and stated they should be conducted every 90 days. The licensee's undated Comprehensive Resident Assessment policy indicated the licensee's assessments would not exceed 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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01640	Continued From page 22 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to execute a service plan for one of three residents (R1). Additionally, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document the agreement on the services to be provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee on November 20, 2024, and began receiving assisted living services. R1's diagnoses included anxiety, depression, and	01640		

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01640	Continued From page 23 schizophrenia (a disorder where a person has delusions and hallucinations). R1's Careplan Tasks dated July 2025 indicated R1 received assistance with room organization and cleaning, laundry, shopping, appointment scheduling, socialization, and medications. R1's file lacked a completed and signed service plan. R2 R2 was admitted to the licensee on September 16, 2023, and began receiving assisted living services. R2's diagnoses included post-traumatic stress disorder, hernia (bulging sac formed in the lining of the abdominal cavity), short term memory difficulties, eczema (chronic inflammation skin condition), generalized pain in the back, knee and wrist. R2's undated Service Plan indicated R2 received assistance with housekeeping, laundry, shopping, socialization, meal preparation, bathing reminders, medication administration, and transportation. R2's Service Plan lacked a signature from R2 or a designated representative. On July 15, 2025, at 1:14 p.m., clinical nurse supervisor (CNS)-C stated they were hired into the CNS role on July 8, 2025. CNS-C stated previous clinical nurse supervisor (PCNS)-B left employment from the licensee on July 9, 2025. On July 15, 2025, at 2:27 p.m., CNS-C was observed looking for the service plan for R1.	01640		

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01640	Continued From page 24 CNS-C stated they were unable to locate the service plan and that should have been completed when R1 was admitted to the facility. On July 17, 2025, at 11:59 a.m., CNS-C stated R2's service plan should have been signed and was not. The licensee's undated Service Plan policy indicated licensee would have a written signed service plan based on the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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	01650		

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01650	Continued From page 25 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the service plan included the required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on October 1, 2022, and began receiving assisted living services. R3's Service Plan dated July 10, 2025, indicated R3 received assistance with housekeeping, laundry, grooming reminders, bathing, mediation, and transportation. R3's diagnoses included sickle cell anemia (a	01650		

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	38155	A. BUILDING: _____ B. WING _____	07/17/2025

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01650	Continued From page 26 blood disorder where the red blood cells are misshaped) and depression. On July 16, 2025, at 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-H administer medications to R3. R3's service plan lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility, and 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. On July 17, 2025, at 11:44 a.m., CNS-C stated they were responsible for the service plans and was unsure why there was missing content. The licensee's undated Service Plan policy indicated the licensee would have a written signed service plan based with the required content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 27 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber's orders were accurately transcribed for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on October 1, 2022, and began receiving assisted living services. R3's diagnoses included sickle cell anemia (a	01760		

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01760	Continued From page 28 blood disorder where the red blood cells are misshaped) and depression. R3's Service Plan dated July 10, 2025, indicated R3 received assistance with mediation assistance. R3's Medication Administration Record dated July 1, 2025 through July 31, 2025 indicated R3 received the following medications: amlodipine 10 mg take 1 tablet once daily, carvedilol 25 mg 1 tablet once daily, Certavite-Antioxidant 18-400 mg-microgram (mcg) 1 tablet once daily, duloxetine 60 mg 1 capsule once daily, apixaban 5 mg take 1 tablet once daily, folic acid 1 tablet once daily, gabapentin 300 mg 1 capsule three times daily, hydroxyurea 500 mg 2 capsules once daily, Incruse Ellipta inhaler 62.5 mcg 1 puff as once daily, magnesium oxide 400 mg one-half tablet once daily, melatonin 10 mg 1 tablet at bedtime, omeprazole 20 mg 1 capsule once daily, pyridoxine 50 mg 2 tablets once daily at bedtime, rosuvastatin 10 mg 1 tablet at bedtime, Suboxone 2-0.5 film place under the tongue once daily, vitamin B12 1000 micrograms (mcg) 1 tablet once daily, vitamin D 1000 units (u) 1 tablet once daily, mirtazapine 7.5 mg 1 tablet once daily, acetaminophen 500 mg take 2 tablets every 6 hours, benzonatate 100 mg 1 capsule three times daily, clotrimazole 1 % apply to feet and buttock twice daily, diclofenac 1 % apply to left shoulder four times daily, loperamide 2 mg capsule as needed, meclizine 25 mg 1 tablet three times daily as needed, methyl salicylate-menthol 15 percent (%) - 10 % apply to chest for pain as needed, methocarbamol 750 mg 1 tablet every six hours as needed, naloxone 4 mg 1 spray into nostril as needed, olanzapine 5 mg 1 tablet as needed, ondansetron 4 mg 2 tablets as needed, oxycodone 5 mg 1 tablet every six hours, Robaxin	01760		

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01760	Continued From page 29 750 mg 1 tablet as needed four times daily, and senna-time 8.6-50 mg 2 tablets twice daily as needed. R3's record included a signed After Visit Summary (AVS) dated July 25, 2025, that indicated R3 was prescribed the following medications: acetaminophen 500 mg take 2 tablets every 6 hours, amlodipine 10 mg take 1 tablet once daily, apixaban 5 mg take 1 tablet once daily, carvedilol 25 mg 1 tablet once daily, Certavite-Antioxidant 18-400 mg-microgram (mcg) 1 tablet once daily, cholecalciferol 1000 units (u) 1 tablet once daily, duloxetine 60 mg 1 capsule once daily, folic acid 1 tablet once daily, gabapentin 1 capsule three times daily, hydroxyurea 500 mg 2 capsules once daily, loperamide 2 mg 2 capsules as needed, magnesium oxide 400 mg one-half tablet once daily, meclizine 25 mg 1 tablet three times daily as needed, melatonin 10 mg 1 tablet at bedtime, methocarbamol 750 mg 1 tablet every six hours as needed, methyl salicylate-menthol 15 percent (%) - 10 % apply to chest for pain as needed, naloxone 4 mg 1 spray into nostril as needed, omeprazole 20 mg 1 capsule once daily, oxycodone 5 mg 1 tablet every six hours, pyridoxine 50 mg 2 tablets once daily at bedtime, and rosuvastatin 10 mg 1 tablet at bedtime. The AVS indicated R3 was prescribed gabapentin 300 mg 1 capsule three times daily, R3's MAR indicated take 2 capsules three times daily. The following medication pyridoxine 50 mg 2 tablets were listed on R3's AVS but not listed on the MAR. On July 16, 2025, at 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-H	01760		

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01760	Continued From page 30 administer oral medications to R3. On July 16, 2025, at 1:25 p.m., clinical nurse supervisor (CNS)-C stated they were responsible for ensuring the signed orders matched the MAR. CNS-C stated they did not have discontinuation orders for the medications. CNS-C stated the prescriber orders and MAR should match and was unsure why there were discrepancies. The licensee's undated Medication Prescription and Refills policy indicated the registered nurse (RN) would make changes to the MAR after receiving a prescription/order for a change in medication or a new medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to maintain current signed prescription orders for all medications the licensee was managing for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01820		

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01820	Continued From page 31 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee on November 20, 2024, and began receiving assisted living services. R1's diagnoses included anxiety, depression, and schizophrenia (a disorder where a person has delusions and hallucinations). R1's Careplan Tasks dated July 2025 indicated R1 received medication assistance. R1's Medication Administration Record (MAR) dated July 1, 2025, through July 31, 2025, indicated R1 received the following medications: atorvastatin 20 milligram (mg) once daily, Lopressor 100 mg twice daily, warfarin 7.5 mg once daily, and nitroglycerin 0.4 mg 1 tablet under the tongue as needed. R1's record contained a prescription for warfarin sodium 5 mg with warfarin sodium 2.5 for a total dose 7.5 mg once daily. R1's file lacked prescriber orders for the remaining medications. R3 R3 was admitted to the licensee on October 1,	01820		

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01820	Continued From page 32 2022, and began receiving assisted living services. R3's diagnoses included sickle cell anemia (a blood disorder where the red blood cells are misshaped) and depression. R3 Service Plan dated July 10, 2025, indicated R3 received assistance mediation assistance. R3's Medication Administration Record dated July 1, 2025 through July 31, 2025 indicated R3 received the following medications: amlodipine 10 mg take 1 tablet once daily, carvedilol 25 mg 1 tablet once daily, Certavite-Antioxidant 18-400 mg-microgram (mcg) 1 tablet once daily, duloxetine 60 mg 1 capsule once daily, apixaban 5 mg take 1 tablet once daily, folic acid 1 tablet once daily, gabapentin 300 mg 1 capsule three times daily, hydroxyurea 500 mg 2 capsules once daily, Incruse Ellipta inhaler 62.5 mcg 1 puff as once daily, magnesium oxide 400 mg one-half tablet once daily, melatonin 10 mg 1 tablet at bedtime, omeprazole 20 mg 1 capsule once daily, pyridoxine 50 mg 2 tablets once daily at bedtime, rosuvastatin 10 mg 1 tablet at bedtime, Suboxone 2-0.5 film place under the tongue once daily, vitamin B12 1000 micrograms (mcg) 1 tablet once daily, vitamin D 1000 units (u) 1 tablet once daily, mirtazapine 7.5 mg 1 tablet once daily, acetaminophen 500 mg take 2 tablets every 6 hours, benzonatate 100 mg 1 capsule three times daily, clotrimazole 1 % apply to feet and buttock twice daily, diclofenac 1 % apply to left shoulder four times daily, loperamide 2 mg capsule as needed, meclizine 25 mg 1 tablet three times daily as needed, methyl salicylate-menthol 15 percent (%) - 10 % apply to chest for pain as needed, methocarbamol 750 mg 1 tablet every six hours as needed, naloxone 4 mg 1 spray into	01820		

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01820	Continued From page 33 nostril as needed, olanzapine 5 mg 1 tablet as needed, ondansetron 4 mg 2 tablets as needed, oxycodone 5 mg 1 tablet every six hours, robaxin 750 mg 1 tablet as needed four times daily, and senna-time 8.6-50 mg 2 tablets twice daily as needed. The following medications were listed on R3's MAR but there were no signed orders: Incruse Ellipta inhaler 62.5 mcg, Suboxone 2-0.5 mg film, mirtazapine 7.5 mg 1 tablet once daily, benzonatate 100 mg 1 capsule three times daily, clotrimazole 1 % apply to feet and buttock twice daily, diclofenac 1 % apply to left shoulder four times daily, olanzapine 5 mg 1 tablet every six hours, ondansetron 4 mg 2 tablets (8 mg) every 8 hours as needed, senna-time 8.6 - 50 mg 2 tablets twice daily as needed. On July 14, 2025, at 7:43 a.m., the surveyor observed ULP-H administer oral medications to R3. On July 15, 2025, at 1:14 p.m., clinical nurse supervisor (CNS)-C stated the signed orders should be available, and the prescription orders may have been mis-filed into a different binder. The licensee's undated Prescription Management Policy and Procedures indicated the licensee would ensure there were signed orders by an authorized medical provider. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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02320	Continued From page 34	02320		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel ((ULP)-H) followed appropriate medication administration procedures when they falsified medical information, completed incorrect documentation of medication, failed to contact the clinical nurse supervisor (CNS) about medications that were not available, and for not following correct procedure for as needed (PRN) medications. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's Service Plan dated July 10, 2025, indicated R3 received medication assistance. R3's Medication Administration Record dated July	02320		

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02320	Continued From page 35 1, 2025, through July 31, 2025, indicated R3 received the following medications: amlodipine 10 mg take 1 tablet once daily, carvedilol 25 mg 1 tablet once daily, Certavite-Antioxidant 18-400 mg-microgram (mcg) 1 tablet once daily, duloxetine 60 mg 1 capsule once daily, apixaban 5 mg take 1 tablet once daily, folic acid 1 tablet once daily, gabapentin 300 mg 1 capsule three times daily, hydroxyurea 500 mg 2 capsules once daily, Incruse Ellipta inhaler 62.5 micrograms (mcg) 1 puff as once daily, magnesium oxide 400 mg one-half tablet once daily, melatonin 10 mg 1 tablet at bedtime, omeprazole 20 mg 1 capsule once daily, pyridoxine 50 mg 2 tablets once daily at bedtime, rosuvastatin 10 mg 1 tablet at bedtime, Suboxone 2-0.5 film place under the tongue once daily, vitamin B12 1000 micrograms (mcg) 1 tablet once daily, vitamin D 1000 units (u) 1 tablet once daily, mirtazapine 7.5 mg 1 tablet once daily, acetaminophen 500 mg take 2 tablets every 6 hours, benzonatate 100 mg 1 capsule three times daily, clotrimazole 1 % apply to feet and buttock twice daily, diclofenac 1 % apply to left shoulder four times daily, loperamide 2 mg capsule as needed, meclizine 25 mg 1 tablet three times daily as needed, methyl salicylate-menthol 15 percent (%) - 10 % apply to chest for pain as needed, methocarbamol 750 mg 1 tablet every six hours as needed, naloxone 4 mg 1 spray into nostril as needed, olanzapine 5 mg 1 tablet as needed, ondansetron 4 mg 2 tablets as needed, oxycodone 5 mg 1 tablet every six hours, Robaxin 750 mg 1 tablet as needed four times daily, and senna-time 8.6-50 mg 2 tablets twice daily as needed. FALSIFYING INFORMATION On July 16, 2025, at 7:43 a.m., the surveyor observed ULP-H obtain R3's vital signs including blood pressure (reading 130/79), pulse (60 beats	02320		

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02320	Continued From page 36 per minute), temperature (98.2 degrees Fahrenheit) and oxygen saturation (96 percent (%). ULP-H opened the electronic medical record (EMAR) and entered the vital sign readings into R3's chart. The surveyor then observed ULP-H review an after-visit summary (AVS) form for R3, which was located in a closet and included a weight for R3 of 160 pounds (lbs). Without asking R3 to verbalize a numerical pain number, the surveyor observed ULP-H enter the number nine into the EMAR for R3's pain rating. Without requesting R3 stand on a weigh scale, ULP-H entered 160 lbs as R3's current weight. On July 16, 2025, at 8:39 a.m., ULP-H stated they were trained to obtain a numerical pain scale from residents. ULP-H stated R3 had been complaining multiple times about pain, so they decided to enter nine as the number. ULP-H stated they were trained to use a scale to obtain a resident's weight. ULP-H stated R3 was in hospital two days ago, and they believed it was okay to use that reading from the AVS. On July 16, 2025, at 9:26 a.m., clinical nurse supervisor (CNS)-C stated staff should use the scale to obtain an accurate weight and should be asking residents to verbalize a numerical number for a pain rating. CNS-C stated staff should not be entering information that was not obtained or measured. The licensee's undated Vital Signs policy indicated staff will accurately monitor and document the resident's vital signs. DOCUMENTING MEDICATIONS AS ADMINISTERED AND FAILED TO CONTACT THE NURSE WHEN A MEDICATION WAS NOT AVAILABLE.	02320		

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02320	Continued From page 37 On July 15, 2025, at 10:35 a.m., during a facility tour, the surveyor did not observe Incruse Ellipta inhaler 62.5 mcg. On July 16, 2025, at 7:43 a.m., the surveyor observed ULP-H administer oral medications to R3. After administering the oral medications, ULP-H returned to the computer and documented the medications as administered on the EMAR. ULP-H did not administer Incruse Ellipta inhaler 62.5 mcg to R3 but documented the medication as administered. On July 16, 2025, at 1:07 p.m., the surveyor asked ULP-H to show where the Incruse Ellipta inhaler was located. The surveyor observed ULP-H search the closet where the medications were stored, and ULP-H was not able to locate the inhaler. ULP-H stated they were trained to contact the nurse if the medication was not available. ULP-H stated they forgot to contact the CNS about the inhaler. ULP-H stated they were unsure why they documented it as administered. On July 16, 2025, at 1:19 p.m., CNS-C stated staff were trained to document the medication was not available and to contact the CNS. CNS-C stated they were unaware there was no Incruse Ellipta inhaler. CNS-C stated they were unsure why ULP-H documented the medication as administered. The licensee's undated Documentation of Medication Administration policy indicated staff should document medications administered, document why a medication was not administered, and to contact the RN if a problem occurred. NOT CALLING THE CNS FOR	02320		

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BRIGHT SIDE HEALTHCARE LLC	2613 65TH AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
02320	Continued From page 38 AUTHORIZATION TO ADMINISTER AS NEEDED (PRN) MEDICATIONS On July 16, 2025, at 7:43 a.m., the surveyor observed ULP-H use the EMAR for medication administration. Without asking R3 to verbalize a numerical pain scale, ULP-H entered nine as R3's pain rating. Without calling a registered nurse (RN), ULP-H reviewed the EMAR, observed acetaminophen 500 mg as a as needed medication (PRN), and placed two acetaminophen 500 mg into a medication cup and administered the medication to R3. On July 16, 2025, at 8:29 a.m. ULP-H stated they were trained by CNS-C to call before administering a PRN medication. ULP-H stated they forgot to contact a RN before giving the acetaminophen. On July 16, 2025, at 9:24 a.m., CNS-C stated staff were trained to contact them before administering the medication. CNS-C stated ULP-H should not have administered the acetaminophen 500 mg to R3 without contacting them. The licensee's PRN (as needed) Medication Process policy indicated a licensed health professional must assess the resident and determine the need for the PRN medications. The policy indicated PRN medication can only be administered by ULPs after RN assessment and writing delegation. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

Bright Side Healthcare LLC
2613 65th Avenue N
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: 0040793

Risk:
License: -1
Expires on: 12/31/2022
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1025251051
Inspection Type: Follow-up - Single
Date: 7/17/2025 Time: 2:00:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Following received from operator in regards to corrections from previous report:

The refrigerator thermostat has been adjusted. Milk and potato salad are now maintained at or below 41°F.
All scratched or peeling non-stick cookware has been discarded. We have replaced these items with a new stainless steel cookware set.
The previously painted and peeling cabinet knobs have been replaced with smooth stainless steel knobs that are durable and easy to clean.
The following areas have been thoroughly cleaned:
> Ceiling and wall around stove
> Floor beneath the stove and refrigerator
> Interior of all cabinets
> Shelves

Renewal for CFPM also discussed, renewal certificate reported received

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 F1025251051 from 7/17/2025

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Bright Side Healthcare LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1025251051
Inspection Type: Follow-up
Date: 7/17/2025
Time: 2:00:00 PM

New Record: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 43 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: Potato salad**; Temperature Process:** Cold-Holding
Location: Refrigerator at 44 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: Salsa**; Temperature Process:** Cold-Holding
Location: Basement refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No