



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 13, 2026

Licensee
Heathers Manor
3000 North Douglas Drive
Crystal, MN 55422

RE: Conditional License Number 421543
Health Facility Identification Number (HFID) 21623
Project Number(s) SL21623016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 21, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, Subd. 1 (a), MDH is issuing a 90-day conditional license, pending appeal.

STATE CORRECTION ORDERS

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

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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of

potential fines that may be assessed related to these correction orders is \$4,000.00. **MDH is not imposing these fines against your license at this time.**

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00
1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$1,000.00
1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - \$1,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

CONDITIONAL LICENSE ISSUED:

MDH will issue Heathers Manor a conditional assisted living facility license for 90 calendar days, pending appeal. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Heathers Manor is in substantial compliance.

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

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

suspension and revocation of the license.

- b. No new admissions:** Heathers Manor will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Heathers Manor must provide the Department:
 - i. A list of the names and birthdates of any individuals Heathers Manor is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. Consultant:** Heathers Manor will contract with an RN to provide consultation concerning all resident(s) to whom Heathers Manor provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Heathers Manor. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Heathers Manor and MDH must review the RN’s credentials and approve the selection. Heathers Manor is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Heathers Manor in an effort to help Heathers Manor align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Heathers Manor will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Heathers Manor and the RN consultant about a change. Each report will be electronically submitted to: HRDConsultantReports.MDH@state.mn.us. The content of the reports will include information such as:
 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;

- v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Heathers Manor to correct the violations cited during the survey as well as to determine the overall practice of Heathers Manor in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.
- g. Corrective Action Plan:** Heathers Manor will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
- i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - i. vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Heathers Manor is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Heathers Manor is in substantial compliance on the follow up survey, MDH will remove the conditions from Heathers Manor's assisted living facility license, and Heathers Manor will correct any outstanding violations identified during the survey. If Heathers Manor is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

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

Heathers Manor

July 13, 2026

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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 Jess Schoenecker directly at: 651-201-3789 or email at: jess.schoenecker@state.mn.us.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER HEATHERS MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422		
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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: SL21623016-0 On May 18, 2026, through May 21, 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 73 residents; 69 receiving services under the Assisted Living Facility license. On May 20, 2026, two immediate correction orders were issued for tag identifications 1750 and 1950. During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scopes and levels were unchanged. An additional immediate correction order for tag identification 2310 was identified during supervisory review and was issued to the	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and 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	0 480			

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0 480	Continued From page 2 a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 480			

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0 480	Continued From page 3 (FBEIR) dated May 19, 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			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included maintaining a current Facility TB Risk Assessment. This practice resulted in a level two violation (a	0 660			

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0 660	Continued From page 4 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment updated March 31, 2026, included incidence and case rates from 2019. The Facility TB Risk Assessment lacked current 2024 data on case rates. On May 20, 2026, at 3:45 p.m., regional clinical director of operations (RDCO)-G stated the current Facility TB Risk Assessment form had been completed using data from 2019. RDCO-G stated the form needed to be updated with current information. The licensee's Employee TB Testing policy updated January 1, 2026, indicated the policy applied to another facility under same ownership in the state of Washington. The Minnesota Department of Health (MDH) Assisted Living Frequently Asked Questions (FAQs) last updated June 5, 2026, indicated each provider licensed by MDH was required to complete a TB risk assessment annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 730	Continued From page 5	0 730			
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 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	0 730			

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0 730	Continued From page 6 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 ensure resident records included a discharge summary for one of one resident who was discharged (R1) and failed to ensure resident records included documentation of services provided for two of three residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on September 6, 2025, and began receiving assisted living services. R1 was discharged from the licensee on February 1, 2026. R1's record included a progress note dated	0 730			

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0 730	Continued From page 7 January 31, 2026, at 1:47 p.m., which read "resident was discharged from facility with all his meds [medications] sent with him". The note was signed by licensed practical nurse (LPN)-H. R1's record lacked a discharge summary to include the following required content: -a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, treatments, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review that includes baseline and current mental, behavioral, and functional status; -a reconciliation of all pre-discharge medications with the resident's post-discharge prescribed and over the counter medications; and -a post-discharge plan which will help the resident adjust to a new living environment. R4 R4 was admitted on August 5, 2025, and began receiving assisted living services. R4's Service Plan Report signed on August 5, 2025, indicated R4's services included medication management, assistance with bathing, vital signs, housekeeping, and safety checks. R4's service log dated May 2026, lacked documentation of services provided for the following services and dates: -daily room order on May 1, 2, 3, 8, 9, 13, and 14; -daily security check on May 8 and 9; and -safety checks on May 2 and 3. R5 R5 was admitted on January 3, 2009, under the	0 730			

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0 730	Continued From page 8 licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's service log dated May 2026, lacked documentation of services provided for the following services and dates: -skin care to feet at bedtime on May 2, 3, 4, 6, 7, 8, 11, 14, 16, 17, and 18; -behavioral monitoring on May 2 and 3; -daily room order on May 2, 3, and 18; -grooming assistance on May 2, 3, and 18; -escorts to meals on May 2, 3, and 18; -bathing assistance on May 2, 6, and 16; and -personal hygiene assistance on May 2, 3, and 18. On May 19, 2026, at 7:39 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R5 with dressing, grooming, personal hygiene, and medication administration. On May 19, 2026, at 11:04 a.m., the surveyor observed ULP-D assist with blood glucose monitoring and insulin administration for R4. On May 19, 2026, at 10:05 a.m., clinical nurse supervisor (CNS)-B stated they were unaware R1's record lacked a discharge summary. On May 20, 2026, at 3:40 p.m., CNS-B stated they were unaware that R4 and R5's records lacked documentation of services. CNS-B stated they did not know why the documentation was incomplete. The licensee's Contents of Resident Record policy revised 2026, indicated resident records would include discharge documentation. The policy also indicated staff would document	0 730			

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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
0 730	Continued From page 9 services provided, observations, changes in condition, interventions, and resident responses. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, 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 May 19, 2026, for the specific violations related the physical environment under Minnesota Statute	0 775			

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0 775	Continued From page 10 144G. TIME PERIOD FOR CORRECTION: SEven (7) days.	0 775			
0 780 SS=A	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 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780			

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0 780	Continued From page 11 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 one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810			

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0 810	Continued From page 12 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: 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).	0 810			

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0 810	Continued From page 13 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility license for four of four employees (unlicensed personnel (ULP)-H, ULP-I, ULP-J, lifestyle enrichment	01290			

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01290	Continued From page 14 (LE)-K)) 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 (problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large number or all the residents). The findings include: ULP-H ULP-H was hired on November 4, 2025, and began providing assisted living services. ULP-H's record included a background study dated October 23, 2025, and was affiliated with another licensee under same ownership. ULP-I ULP-I was hired on December 24, 2025, and began providing assisted living services. ULP-I's record included a background study dated December 17, 2025, and was affiliated with another licensee under the same ownership. ULP-J ULP-J was hired on March 23, 2026, and began providing assisted living services. ULP-J's record included a background study dated March 10, 2026, and was affiliated with another licensee under the same ownership. LE-K LE-K was hired on April 6, 2026, and began	01290			

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01290	Continued From page 15 providing assisted living services. LE-K's record included a background study dated March 27, 2026, and was affiliated with another licensee under the same ownership. ULP-H, ULP-I, ULP-J, and LE-K's records lacked background studies affiliated with the licensee. On May 18, 2026, at 1:41 p.m., licensed assisted living director (LALD)-A stated the business office manager did not have access to the licensee's health identification number (HFID) in NetStudy, so they had been affiliating new employees to another HFID under the same ownership. The licensee's Pre-employment Reference and Background Checks policy revised on January 1, 2026, indicated all applicants would be required to pass a comprehensive criminal background check prior to their first day of work. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the	01320			

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01320	Continued From page 16 topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This had the potential to affect all residents living in 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on June 10, 2025, and began providing assisted living services. ULP-D was hired on April 27, 2026, and began providing assisted living services. ULP-C and ULP-D's records lacked documentation of training and competency for all	01320			

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01320	Continued From page 17 required training to include: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On May 19, 2026, at 7:52 a.m., the surveyor observed ULP-D assisting R5 with morning cares. On May 20, 2026, at 8:28 a.m., clinical nurse supervisor (CNS)-B stated they had a recent internal audit and training, and competencies were identified as an area of improvement. CNS-B stated they did not provide training and competency validation for ULP-D (who was	01320			

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01320	Continued From page 18 recently hired). The licensee's Training and Competency Evaluations for Unlicensed Personnel policy revised on January 1, 2026, indicated training and competency evaluations of ULPs would be conducted by a registered nurse (RN), or another instructor in conjunction with the RN, and would include all the areas listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320			
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by:	01330			

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01330	Continued From page 19 Based on observation, interview, and record review, the licensee failed to ensure required training was completed and documented for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This had the potential to affect all residents living in 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on June 10, 2025, and began providing assisted living services. ULP-D was hired on April 27, 2026, and began providing assisted living services. ULP-C and ULP-D's records lacked documentation of training and competency for all required training to include: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physician, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motion and positioning; and -administering medications and treatments as required.	01330			

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01330	Continued From page 20 On May 19, 2026, at 7:52 a.m., the surveyor observed ULP-D assisting R5 with morning cares. On May 20, 2026, at 8:28 a.m., clinical nurse supervisor (CNS)-B stated they had a recent internal audit and training, and competencies were identified as an area of improvement. CNS-B stated they did not remember if they had provided training and competency validation for ULP-D (who was recently hired). The licensee's Training and Competency Evaluations for Unlicensed Personnel policy revised on January 1, 2026, indicated training and competency evaluations of ULPs would be conducted by a registered nurse (RN), or another instructor in conjunction with the RN, and would include all the areas listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered	01440			

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01440	Continued From page 21 nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure supervision was completed within 30 calendar days after hire and beginning to provide the delegated tasks to residents for one of two unlicensed personnel (ULP)-C). 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 client'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 electronic medication administration record (EMAR) dated May 2026, indicated ULP-C had administered medications to R3 on May 8 and 17, 2026. ULP-C was hired on June 10, 2025, and began	01440			

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01440	Continued From page 22 providing assisted living services. ULP-C's employee record lacked documentation of direct supervision of delegated tasks within 30 days of hire or beginning to provide delegated tasks to residents. On May 20, 2025, at 8:28 a.m., clinical nurse supervisor (CNS)-B stated ULP-C did not have a 30-day supervision form in their employee record. CNS-B stated he did not remember completing a 30-day supervision for ULP-C. The licensee's Nurse Delegation policy dated 2026, indicated the licensee would ensure nursing delegation is completed in accordance with Minnesota 144G Assisted Living regulations and accepted nursing standards of practice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the	01460			

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01460	Continued From page 23 staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed orientation to assisted living facility licensing requirements and regulations, before providing services, for one of two employees (unlicensed personnel (ULP)-C). 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	01460			

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01460	Continued From page 24 situation has occurred only occasionally). The findings include: ULP-C was hired on June 10, 2025, and began providing assisted living services. ULP-C's personnel record lacked documentation of orientation to include the following required content: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - assisted living bill of rights; - handling of resident complaints, reporting of complaints, and where to report; - 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; - 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 and how they apply to direct support services provided by the staff person. On May 20, 2026, at 8:28 a.m., clinical nurse supervisor (CNS)-B stated they did not remember if ULP-C had attended orientation. CNS-B stated there would be an orientation checklist in ULP-C's personnel file.	01460			

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01460	Continued From page 25 On May 20, 2026, at 10:48 a.m., regional director of clinical operations (RDCO)-G stated that the licensee had recently had an internal audit, and orientation was an area identified for improvement. The licensee's Orientation policy revised on August 1, 2021, indicated all employees would attend an orientation before providing services to residents. The policy indicated the orientation would include the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia 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),	01530			

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01530	Continued From page 26 and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed at least eight (8) hours of initial training on dementia care topics and two hours of initial training on mental illness and de-escalation topics within 160 working hours of the employment start date for one of two employees (unlicensed personnel (ULP)-C). 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	01530			

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01530	Continued From page 27 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: ULP-C was hired on June 10, 2025, and began providing assisted living services. ULP-C's record included a Relias (online training) transcript dated May 20, 2026, indicating ULP-C completed five hours of dementia training and 0.1 hours of de-escalation training between October 22, 2025, and February 4, 2026. ULP-C's employee record lacked evidence of at least eight hours of initial dementia training within 160 working hours of the employment start date to include: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; and -person-centered planning and service delivery. ULP-C's employee records lacked evidence they completed 2 hours of initial training on mental illness within 160 hours of start date, effective July 1, 2025, to include the following topics: (1) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (2) de-escalation techniques and communication; and (3) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines.	01530			

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01530	Continued From page 28 On May 20, 2026, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated ULP-C would have completed 160 working hours before starting her dementia training. CNS-B stated they did not know why the training was not completed within the required 160 working hours. The licensee's Orientation policy dated August 1, 2021, indicated orientation would include dementia training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	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 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	01620			

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01620	Continued From page 29 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 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 the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 90 days after the previous assessment for two of three residents (R4, R5). This practice resulted in a level two violation (a	01620			

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01620	Continued From page 30 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 the residents). The findings include: R4 R4 was admitted on August 5, 2025, and began receiving assisted living services. R4's Service Plan Report signed on August 5, 2025, indicated R4's services included assistance with bathing, monthly vital signs, and medication management R4's record included nursing assessments completed by an RN on August 20, 2025, November 23, 2025, and March 2, 2026, indicating 92 days had passed between the assessment completed in August and November 2025, and 102 days had passed between the assessment completed in November 2025, and March 2026. R5 R5 was admitted on January 3, 2009, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's record lacked a service plan. R5's record included nursing assessments completed by an RN on August 7, 2025, November 10, 2025, and March 24, 2026,	01620			

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01620	Continued From page 31 indicating 95 days had passed between the assessments completed August 2025, and November 2025, and 134 days had passed between assessments completed in November 2025, and March 2026. On May 20, 2026, at 3:48 p.m., clinical nurse supervisor (CNS)-B stated they were unaware the assessments were completed later than the 90-day requirement. The licensee's Nurse Assessment policy dated January 1, 2017, indicated the licensee would ensure nursing assessments would be completed in accordance with Minnesota 144G Assisted Living regulations and accepted nursing standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service	01650			

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01650	Continued From page 32 cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R3, R4, R7). 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 the residents). The findings include: R3 R3 was admitted on November 18, 2025, and began receiving assisted living services. R3's Service Plan Report signed on November	01650			

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01650	Continued From page 33 18, 2025, indicated R3's services included assistance with dressing, bathing, and transfers. R3's service plan lacked the following required content: -the schedule and methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. R4 R4 was admitted on August 5, 2025, and began receiving assisted living services. R4's Service Plan Report signed on August 5, 2025, indicated R4's services included assistance with bathing, medication administration, and monthly vital signs. R4's service plan lacked documentation of the following required information: -a description of all services provided (blood glucose management); -the schedule and methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. R7 R7 was admitted on October 21, 2024, and began receiving assisted living services. R7's undated, unsigned Service Plan Report indicated R7's services included assistance with medication administration and laundry. R7's service plan lacked documentation of the following required information: -the schedule and methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services.	01650			

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01650	Continued From page 34 On May 20, 2026, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated they were unaware the service plans lacked required content. CNS-B stated they did not know why the service plans were incomplete. The licensee's Service Plan policy dated January 1, 2017, indicated residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others	01700			

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01700	Continued From page 35 who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a medication management assessment which included all content prior to providing medication management services for two of three residents receiving medication management services (R4, R5). 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 impacted to has the potential to impact a large portion or all of the residents). The findings include: R4 R4 was admitted on August 5, 2025, and began receiving assisted living services. R4's Service Plan Report signed on August 5, 2025, indicated R4's services included assistance with bathing, medication administration, and monthly vital signs.	01700			

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01700	Continued From page 36 R4's Minnesota AL Comprehensive Assessment (nursing assessment) dated March 2, 2026, included an assessment for medication management. R5 R5 was admitted on January 3, 2009, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's record lacked a service plan. On May 20, 2026, at 7:48 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R5. R5's Minnesota AL Comprehensive Assessment (nursing assessment) dated March 24, 2026, included an assessment for medication administration. R4 and R5's medication assessments lacked the following required content: -an identification and review of all medications the resident is known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address those issues; and -identification of the interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On May 20, 2026, at 3:45 p.m., regional director	01700			

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01700	Continued From page 37 of clinical operations (RDCO)-G stated the lack of required content in the medication assessment was a system issue and they would add the required content to the assessments. The licensee's Medication Management Assessment policy dated January 1, 2026, indicated the licensee would complete comprehensive medication management assessments for all residents receiving medication management services in accordance with Minnesota 144G Assisted Living regulations, physician orders, and accepted nursing standards of practice. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730			

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NAME OF PROVIDER OR SUPPLIER HEATHERS MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422		
(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
01730	Continued From page 38 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to review and update a medication management plan annually for two of three residents (R5, R7) and failed to develop an individualized medication management plan with all required content for three of three residents (R4, R5, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730			

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01730	Continued From page 39 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: R4 R4 was admitted on August 5, 2025, and began receiving assisted living services. R4's Service Plan Report signed on August 5, 2025, indicated R4's services included assistance with bathing, monthly vital signs, and medication management. R4's Medication/Treatment/Therapy Management plan dated August 5, 2025, lacked identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis. R5 R5 was admitted on January 3, 2009, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's record lacked a service plan. On May 20, 2026, at 7:48 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R5. R5's Medication/Treatment/Therapy Management plan was dated June 7, 2023, indicating the plan had not been reviewed or updated for over two	01730			

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01730	Continued From page 40 (2) years and eleven (11) months. The plan also lacked a description of storage of medications based on resident's needs, preferences, risk of diversion, and consistent with manufacturer's directions. R7 R7 was admitted on October 21, 2024, and began receiving assisted living services. R7's undated and unsigned Service Plan Report indicated R7's services included assistance with medication administration and laundry. R7's Medication/Treatment/Therapy Management plan was dated June 7, 2023, indicating the plan had not been reviewed or updated for over 2 years and 11 months. The plan also lacked a description of storage of medications based on resident's needs, preferences, risk of diversion, and consistent with manufacturer's directions. On May 20, 2026, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated they were unaware the medication management plans were incomplete and stated they did not know why the plans were not reviewed or updated annually. The licensee's Medication and Treatment plan policy dated January 1, 2017, indicated the licensee would ensure all residents had a medication and treatment plan according to their needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

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01750	Continued From page 41	01750			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure, prior to delegating the task of medication administration, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and the ULP demonstrated competency back to the RN for two of two employees (ULP-C, ULP-D). 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: R4's Medication Administration Record (MAR)	01750	During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope and level are unchanged.		

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01750	Continued From page 42 dated May 2026, indicated ULP-C administered medications to R4 on May 18 and ULP-D administered medications to R4 on May 1, 13, 14, and 19. R5's MAR dated May 2026, indicated ULP-C had administered medications to R5 on May 9 and 18 and ULP-D had administered medications to R5 on May 1, 13, 14, and 19. R7's MAR dated May 2026, indicated ULP-C had administered medications to R7 on May 9 and 18 and ULP-D had administered medications to R7 on May 1, 13, and 19. ULP-C ULP-C was hired on June 10, 2025, and began providing assisted living services. ULP-C's record lacked documentation that training and competency evaluation for medication administration had been completed by a RN. ULP-D ULP-D was hired on April 27, 2026, to provide assisted living services. On May 19, 2026, at 7:39 a.m., the surveyor observed ULP-D obtain and prepare R5's medications from the locked medication file cart. ULP-D dispensed calcium D 600/400 tablet (supplement), gabapentin 100 milligrams (mg) (anti-convulsant), lorazepam 0.5 mg (controlled substance anti-anxiety medication), prednisone 7.5 mg (corticosteroid), aripiprazole 10 mg (antipsychotic), escitalopram 20 mg (antidepressant), levothyroxine 150 micrograms (mcg) (treats hypothyroidism), ziprasidone 40 mg (antipsychotic), and acetaminophen 1000 mg	01750			

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01750	Continued From page 43 (pain reliever) into a medication cup, verifying each medication against the MAR. ULP-D prepared polyethylene glycol powder 17 grams (laxative) into a cup with water. ULP-D then administered the medications listed above to R5. On May 19, 2026, at 11:40 a.m., the surveyor observed ULP-D remove a box labeled with R4's name from the locked medication cart. The box contained insulin pens, needles, alcohol swabs, and a continuous glucose monitor reader. ULP-D took the box to R4's room and identified R4. ULP-D handed the blood glucose monitor reader to R4 and asked him to scan the sensor on his left arm, which he did and obtained a blood glucose reading of 160. ULP-D stated that since the blood glucose was greater than 150, they would administer 20 units of Humalog insulin as ordered by the prescriber. ULP-D cleaned R4's right upper abdomen with an alcohol swab and dialed 11 units into a Humalog Kwik injection insulin pen, checking against the MAR. ULP-D asked R4 to verify the amount. ULP-D administered the Humalog insulin and called clinical nurse supervisor (CNS)-B for a new pen which was delivered to the resident's room. ULP-D checked the new Humalog insulin pen against the MAR and set up the pen for 9 units. ULP-D cleaned R4's upper left abdomen and asked R4 to verify the pen was set at 9 units prior to administering the insulin. ULP-D then documented the insulin as given. On May 19, 2026, at 11:32 a.m., the surveyor observed ULP-D remove a box from the medication cart labeled with R7's name, containing insulin pens and supplies. ULP-D took the box to R7's room and identified R7. ULP-D removed the Novolog insulin flex pen, checked it against the MAR, and set the dosage to 12 units.	01750			

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01750	Continued From page 44 ULP-D asked R7 to verify the dose and administered the insulin into R7's abdomen. ULP-D documented the insulin administration on the MAR. ULP-D's record lacked documentation of training and competency evaluation by a RN for medication administration. On May 19, 2026, at 9:00 a.m., ULP-D stated she worked part time and was trained to administering medications by working with a colleague for "a few days". ULP-D stated she had recently completed physician assistant training but was not yet licensed. On May 20, 2026, at 9:11 a.m., CNS-B stated they do not remember if a competency evaluation had been completed for ULP-C. CNS-B stated they did not do a competency evaluation for ULP-D on medication and insulin administration. CNS-B stated they recently had an audit and were working on putting competency and training documentation into place. The licensee's Nurse Delegation policy dated January 2014, and revised in 2026, indicated only an RN would delegate nursing tasks in accordance with Minnesota law and professional standards. The policy also identified medication administration as a delegated task and would include return demonstration and observation by a licensed nurse. The policy indicated documentation of competency would be maintained in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750			

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01880	Continued From page 45	01880			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were stored in a securely locked and substantially constructed compartments according to manufacturer's directions and permit only authorized personnel to have access. 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: R4 R4 was admitted on August 5, 2025, and began receiving assisted living services. R4's Service Plan Report signed on August 5, 2025, indicated R4's services included assistance with bathing, monthly vital signs, and medication management. R7	01880			

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01880	Continued From page 46 R7 was admitted on October 21, 2024, and began receiving assisted living services. R7's undated and unsigned Service Plan Report indicated R7's services included assistance with medication administration and laundry. OPEN UNDATED INSULIN R4's Medication Administration Record dated May 2026, indicated R4 received Lantus insulin 45 units every morning and 55 units every evening. R7's MAR dated May 2026, indicated R7 received Basaglar insulin 5 units every evening. On May 18, 2026, at 12:02 p.m., during a medication cart review with clinical nurse supervisor (CNS)-B, the surveyor observed an undated Lantus insulin pen for R4 and an open, undated Basaglar insulin pen for R7. On May 18, 2026, at 12:02 p.m., CNS-B confirmed the insulin pens had been used and were undated. CNS-B stated, "I guess I will need to do some additional training". MEDICATIONS AT BEDSIDE R7's Order Summary Report signed by a prescriber on February 5, 2026, lacked an order for Debrox ear drops or Systane eye drops. R7's Medication/Treatment/Therapy Management plan dated June 7, 2023, indicated R7's services included medication administration. The plan lacked documentation that R7 was able to self-administer medications or store medications at the bedside. On May 19, 2026, at 11:04 a.m., the surveyor observed ULP-D administer medications to R7.	01880			

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01880	Continued From page 47 The surveyor observed Debrox ear drops and Systane eye drops (over the counter medications) on R7's dresser. On May 19, 2026, at 11:10 a.m., ULP-D stated she did not administer the ear or eye drops and confirmed they were not listed on R7's MAR. ULP-D stated she did not know if R7 had physician orders for the medications or if they were approved to be kept at the bedside. On May 20, at 8:28 a.m., CNS-B stated they were unaware there were medications at R7's bedside. CNS-B stated "sometimes the family brings them in". The Lantus package insert developed by Sanofi-Aventis and revised June 2023, indicated Lantus that has been opened (refrigerator or room temperature) should be discarded after 28 days. The Basaglar package insert developed by Eli Lilly and revised in July 2021, indicated Basaglar that has been opened (refrigerator or room temperature) should be discarded after 28 days. The licensee's Medication Storage policy dated July ,1 2024, indicated medications that were managed and stored by the licensee would be kept in an area designated and equipped for drug preparation and locked storage convenient to each workstation. The licensee's Medication Management Program policy dated December 26, 2022, indicated all medications would have a valid physician or licensed prescribed order prior to administration. No further information was provided.	01880			

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01880	Continued From page 48	01880			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the disposition of the medications in the resident's record, 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	01910			

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01910	Continued From page 49 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on September 6, 2025, and began receiving assisted living services. R1 was discharged from the licensee on February 1, 2026. R1's record included a progress note dated January 31, 2026, at 1:47 p.m., which read "resident was discharged from facility with all his meds [medications] sent with him". The note was signed by licensed practical nurse (LPN)-H. R1's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On May 19, 2026, at 10:05 a.m., clinical nurse supervisor (CNS)-B stated they were unaware R1's record lacked a discharge summary. CNS-B stated they did not know why the medication disposition was not completed. The licensee's Medication Management Program policy dated December 26, 2022, indicated the licensee would maintain a safe and effective medication management program in compliance with Minnesota 144G Assisted Living regulations, physician orders, pharmacy standards, and	01910			

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01910	Continued From page 50 accepted nursing practices. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
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 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	01940			

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01940	Continued From page 51 changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (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 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: R4 was admitted on August 5, 2025, and began receiving assisted living services. R4's record included Medication Review Report (provider's orders), signed by R4's provider on July 29, 2025. Provider orders included an order for blood glucose monitoring twice daily. R4's Service Plan signed on August 5, 2025, lacked a statement indicating blood glucose monitoring would be provided. R4's Medication/Treatment/Therapy Management Plan dated August 5, 2025, lacked identification of blood glucose monitoring as a provided service. R4's Medication Administration Record dated May	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER HEATHERS MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3000 NORTH DOUGLAS DRIVE CRYSTAL, MN 55422		
(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
01940	Continued From page 52 2026, indicated blood glucose monitoring was being provided twice daily. On May 19, 2026, at 10:05 a.m., clinical nurse supervisor (CNS)-B stated they were unaware that R4's service plan and treatment management plan lacked identification of blood glucose management as a service provided. CNS-B stated, "but we are doing it". The licensee's Medication and Treatment Plan policy dated January 1, 2017, indicated the licensee would ensure all residents have a medication and treatment plan according to their needs of services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=I	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 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	01950			

Minnesota Department of Health

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01950	Continued From page 53 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 ensure, prior to delegating nursing tasks of treatment administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform blood glucose testing and the ULP demonstrated competency back to the RN for two of two employees (ULP-C, ULP-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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: R4's Medication Administration Record (MAR) dated May 2026, indicated ULP-C provided blood glucose monitoring for R4 on May 18 and administered insulin based on the blood glucose results. R4's MAR also indicated ULP-D provided blood glucose monitoring for R4 on May 1, 13, and 19 and administered insulin based on the blood glucose results. R7's MAR dated May 2026, indicated ULP-C had provided blood glucose monitoring for R7 on May 18 and ULP-D had provided blood glucose	01950	During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope and level are unchanged.		

Minnesota Department of Health

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01950	Continued From page 54 monitoring for R7 on May 1 and 19. ULP-C ULP-C was hired on June 10, 2025, and began providing assisted living services. ULP-C's record lacked documentation that training and competency evaluation for blood glucose monitoring had been completed by a RN. ULP-D ULP-D was hired on April 27, 2026, to provide assisted living services. ULP-D's record lacked documentation that training and competency evaluation for blood glucose monitoring had been completed by a RN. On May 19, 2026, at 11:40 a.m., the surveyor observed ULP-D remove a box labeled with R4's name from the locked medication cart. The box contained insulin pens, needles, alcohol swabs, and a continuous glucose monitor reader. ULP-D took the box to R4's room and identified R4. ULP-D handed the blood glucose monitor reader to R4 and asked him to scan the sensor on his left arm, which he did and obtained a blood glucose reading of 160. ULP-D stated that since the blood glucose was greater than 150, they would administer 20 units of Humalog insulin as ordered by the prescriber. On May 20, 2026, at 9:11 a.m., clinical nurse supervisor (CNS)-B stated they do not remember if a competency evaluation had been completed for ULP-C. CNS-B stated they did not do a competency evaluation for ULP-D on blood glucose monitoring. CNS-B stated they recently had an audit and were working on putting competency and training documentation into	01950			

Minnesota Department of Health

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01950	Continued From page 55 place. The licensee's Nurse Delegation policy dated January 2014, and revised in 2026, indicated only an RN would delegate nursing tasks in accordance with Minnesota law and professional standards. The policy also identified blood glucose monitoring as a delegated task and would include return demonstration and observation by a licensed nurse. The policy indicated documentation of competency would be maintained in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01950			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents who utilized bed rails (R3, R5). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was	02310			

Minnesota Department of Health

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02310	Continued From page 56 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: R3 R3 was admitted on November 18, 2025, and began receiving assisted living services. R3's Individual Service Plan Report signed on November 18, 2025, indicated R3's services include assistance with bathing, dressing, transfers, and safety checks. R3's comprehensive nursing assessment dated March 11, 2026, indicated R3 was a risk for falls and required assistance with transfers and mobility. R3's record included a Device Evaluation dated May 6, 2026, indicating R3 used quarter bed rails on both sides of her bed. The evaluation lacked measurements for potential entrapment zones. On May 20, 2026, at 1:15 p.m., the surveyor observed R3's hospital bed with bilateral quarter bed rails. The right rail on the bed was loose and able to move side to side and back and forth. R5 R5 was admitted on January 3, 2009, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's record lacked a service plan. R5's record included Device Evaluations (bedrail	02310			

Minnesota Department of Health

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02310	Continued From page 57 assessments) dated November 19, 2025, and April 30, 2026, indicating 162 days had passed between bed rail assessments. Additionally, the bed rail assessments lacked measurements of potential entrapment zones. On May 20, 2026, at 1:10 p.m., the surveyor observed R5's hospital bed with bilateral quarter rails. The rail on the left side of the bed was loose and easily moved side to side and back and forth. On May 20, 2026, at 1:20 p.m., the surveyor reported the loose bed rails to clinical nurse supervisor (CNS)-B. CNS-B stated the R3's bedrails were installed when R3 returned from the hospital on March 13, 2026. CNS-B stated they were unaware that actual bed rail measurements were required documentation. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), updated April 17, 2026, indicated, documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The residents' preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".	02310			

Minnesota Department of Health

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02310	Continued From page 58 Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Bed Rail policy dated August 25, 2025, indicated the licensee would use a person-centered approach when determining the use of bed rails. The policy also indicated when bed rails were used, the licensee would ensure correct installation, use, and maintenance of the rails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

HEATHERS MANOR
3000 NORTH DOUGLAS DRIVE
Crystal, MN 55422
Hennepin County
Parcel:

Phone:

License Info

License: HFID 21623

Risk:
License:
Expires on:
CFPM: Jireh D. Essiomley
CFPM #: 124942; Exp: 08/23/2027

Inspection Info

Report Number: F8044261153
Inspection Type: Full - Single
Date: 5/19/2026 Time: 11:02:55 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

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

3-304.15A *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0287A Single-use gloves must be used for only one task and be discarded when damaged or soiled, or when interruptions occur in the operation.

COMMENT: Observed staff use gloves soiled by dirty dishes to handle clean dishes.

Gloves changed upon request.

Comply By: 5/19/2026 Originally Issued On: 5/19/2026

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114F *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0805F Provide and maintain a chemical sanitizer generated by a device on site at the food establishment that complies with 7US Code 136 to 136q, 40CFR.152.500 and 156.10, displays the US EPA device manufacturing facility registration number on the device and is operated and maintained according to manufacturer's instructions.

COMMENT: Sink and surface sanitizer concentration measured at 2258 ppm, which exceeds the manufacturer's maximum level.

Water will be added to solution until unit is repaired.

Comply By: 5/19/2026 Originally Issued On: 5/19/2026

New Order: 4-600 Cleaning Equipment and Utensils

4-602.11E *Priority Level: Priority 3 CFP#: 16*

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

COMMENT: Mold in ice machine.

Comply By: 5/19/2026 Originally Issued On: 5/19/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.11 *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

COMMENT: No hand soap at handwashing sink in cafe.

Comply By: 5/19/2026 Originally Issued On: 5/19/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.12 *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

COMMENT: No paper towels at handwashing sink in cafe.

Comply By: 5/19/2026 Originally Issued On: 5/19/2026

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.14A *Priority Level: Priority 3 CFP#: 10*

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.

COMMENT: Sign not posted at handwashing sink in cafe.

Comply By: 5/19/2026 Originally Issued On: 5/19/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Michelle Winters. Inspection report reviewed on site with Alessandro.

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 Rochester District Office inspection report number F8044261153 from 5/19/2026

Alessandro Naldi



Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

HEATHERS MANOR
Crystal
County/Group: Hennepin County

Inspection Info

Report Number: F8044261153
Inspection Type: Full
Date: 5/19/2026
Time: 11:02:55 AM

Food Temperature: Product/Item/Unit: Soup; Temperature Process: Cooling

Location: Walk-in Cooler at 135.4 Degrees F.

Comment: 11:00am

Violation Issued?: No

Food Temperature: Product/Item/Unit: Mashed potatoes; Temperature Process: Cold-Holding

Location: Walk-in Cooler at 39.6 Degrees F.

Comment:

Violation Issued?: No

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

Location: Walk-in Cooler at 37.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Hamburger patties; Temperature Process: Cooking

Location: Grill at 180.3 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Gravy; Temperature Process: Hot-Holding

Location: Steam Table at 178.4 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Cut tomatoes; Temperature Process: Cold-Holding

Location: Cold Well at 41.4 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Chicken; Temperature Process: Cold-Holding

Location: Prep Cooler at 39.6 Degrees F.

Comment:

Violation Issued?: No

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

Location: Prep Cooler at 40.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk; Temperature Process: Cold-Holding

Location: Upright Cooler at 39.6 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 35.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Mashed potatoes; **Temperature Process:** Cooling

Location: Walk-in Cooler at 103.2 Degrees F.

Comment: 11:59am

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Page: 1

Establishment Info

HEATHERS MANOR
Crystal
County/Group: Hennepin County

Inspection Info

Report Number: F8044261153
Inspection Type: Full
Date: 5/19/2026
Time: 11:02:55 AM

Sanitizing Chemical: Product: Lactic Acid; **Sanitizing Process:** Dispenser

Location: Dishwashing Area **Equal To** 2258 PPM

Comment:

Violation Issued?: Yes

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

Location: Dishwashing Area **Equal To** 165.1 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Lactic Acid; **Sanitizing Process:** Wiping Cloth Bucket

Location: Prep Area **Equal To** 1675 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Lactic Acid; **Sanitizing Process:** Wiping Cloth Bucket

Location: Grill **Equal To** 704 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL21623016-0	Date: May 19, 2026
Facility Name: Heathers Manor	
Facility Address: 3000 Douglas Dr N, Crystal, MN 55422	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

Comments: The resident room doors throughout the facility were equipped with self-closing hinges, a smoke seal around the frame, a rated fire tag on the frame and on the door. Multiple unit doors throughout the facility were found to be held in the open position by a magnetic holder that was not tied into the fire alarm system. Multiple other resident room doors were found to be equipped with the same magnetic hold open devices that were not in use at the time of the survey.

3. Interior vertical shafts, including stairways, elevator hoistways, and service and utility shafts, that connect two of more stories of a building, shall be enclosed or protected. When openings are required to be protected, opening protectives shall be maintained self-closing. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.4, 1103.4.1]

Comments: The third floor trash chute door would not close on its own from the open position.

4. Gates used as a component in a means of egress shall meet the same requirements for doors. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]

Comments: The gate from the courtyard leading to the public way was equipped with a mag lock that could only be operated by using a number code on the keypad to the left side of the gate.

5. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

Comments: The marked exit door on the first floor east wing was equipped with a mag lock that could only be operated by using a number code on the keypad located to the left side of the door.

6. Gas fired commercial cooking appliances installed on casters and appliances that are moved for cleaning and sanitation purposes shall be connected to the piping system with a connector complying with ANSI Z21.69. Movement of appliances on casters shall be limited by a restraining device installed in accordance with the connector and appliance manufacturer's instructions. [Minn. Stat. 144G.45 subd. 2; MSFC 607.4]

Comments: The gas fired cooking equipment in the kitchen was found to be not attached to the tethers behind the cooking equipment.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 1; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: The smoke alarms in resident room 123 would not sound as interconnected when tested by maintenance supervisor (MS)-F. The smoke alarms sounded locally in both resident rooms and common hallway only.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. 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: MS-F stated that residents receive training on the FSEP annually. No documentation of residents being offered training on the FSEP was provided during the survey.