Electronically Delivered

June 11, 2026

Licensee
Bell Assisted Living LLC
11947 9th Avenue Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL37987016

Dear Licensee:

On June 9, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 11, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

KKM

Electronically Delivered

Marh 11, 2026

In the Matter of Bell Assisted Living LLC
Bell Assisted Living LLC
11947 9th Avenue Northwest
Coon Rapids, MN 55433

RE: MDH Health Facility Identification Number 37987
License Number 419721
Project Number SL37987016

STIPULATION AND CONSENT ORDER:
It is stipulated and agreed by Bell Assisted Living LLC and the Minnesota Department of Health ("Department" or "MDH"), that without a hearing or adjudication under the procedures outlined in Minn. Stat. § 144G.20 and/or Minn. Stat § 144G.32, both parties agree to enter into this Stipulation and Consent Order.

This Stipulation and Consent Order ("Stipulation"), survey results, dated April 11, 2025, and related enforcement and investigation documents shall constitute the entire record upon which this Stipulation is based. These documents, dated through the date of this Stipulation, listed below in the Facts and Law, are incorporated by reference into this Stipulation.

FACTS AND LAWS:

1. Minn. Stat. § 144G.01 - Minn. Stat. § 144G.95, authorize MDH to regulate licensed assisted living facilities in Minnesota. This authority includes issuing licenses and conducting surveys to determine if a license holder complies with statutory requirements of licensed assisted living facilities.

2. Bell Assisted Living LLC has been licensed to provide assisted living services since January 31, 2022.

3. On April 11, 2025, the Department conducted a full survey for the purpose of assessing compliance with State licensing regulations (Project Number SL37987016). This survey resulted in 26 orders, including 26 Level 2/Widespread.

4. On January 14, 2026, the Department conducted a follow-up survey for the purpose of assessing compliance with State licensing regulations (Project SL37987016). This follow-up survey resulted in 18 orders, including 17 Level 2/Widespread.

5. MDH sent a letter on January 21, 2026, informing Bell Assisted Living LLC of the

follow-up survey violations and fines imposed. The enforcement letter notified Bell Assisted Living LLC of its options to exercise hearing rights and reconsideration rights. Additionally, the letter instructed Bell Assisted Living LLC to contact MDH to schedule an informal conference.

CURRENT STATUS:
Bell Assisted Living LLC owner, Lensa Mekonnen, met informally with MDH during a conference call on February 5, 2026.

Bell Assisted Living LLC was informed of the opportunity to have representation (including a lawyer) present during this informal conference. During this call, MDH shared their concerns about the **survey** completed on April 11, 2025, and the follow-up survey completed **January 14, 2026,** and provided Bell Assisted Living LLC with the option of a Stipulation and Consent Order to resolve those concerns and fines. During the informal conference, Bell Assisted Living LLC shared what actions they are taking to bring Bell Assisted Living LLC into compliance. Under this agreement, Bell Assisted Living LLC will take immediate steps to correct all violations while operating under a conditional license.

CONDITIONAL LICENSE ISSUED:
Under this Stipulation and Consent Order, MDH will issue Bell Assisted Living LLC a conditional assisted living facility license for 90 calendar days from the date this Stipulation is fully executed (signed). Conditional licenses are addressed in Minn. Stat. § 144G.20. The conditions will be effective immediately upon execution of this Stipulation. 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 survey, MDH will determine if Bell Assisted Living LLC is in compliance with 144G and the conditions imposed by this Stipulation. If the licensee is in substantial compliance, conditions will be lifted.

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:** Bell Assisted Living LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Bell Assisted Living LLC must provide the Department:

    i. A list of the names and birth dates of any individuals Bell Assisted Living LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents:

1. Name and birth date of each resident

Current payment source for services

2. If Elderly Waiver, the name and contact information of the care coordinator/case manager
3. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

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

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Bell Assisted Living LLC and the RN consultant about a change. Each report will be electronically submitted to: **HRDConsultantReports.MDH@state.mn.us.** The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;

vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced follow up surveys under Minn. Stat. § 144G.30 subds. 6 and 7 to assess the progress of Bell Assisted Living LLC to correct the violations cited during the follow-up survey as well as to determine the overall practice of Bell Assisted Living LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive 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:** Bell Assisted Living LLC will develop and work within a corrective action plan (CAP)(Minn. Stat. § 144G.30, Subd. 5 (c). 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 corrections
   vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP SURVEY DURING THE CONDITIONAL LICENSE PERIOD: MDH will determine if Bell Assisted Living LLC is in compliance based on the results of the follow up survey conducted pursuant to Minn. Stat. § 144G.30, Sub. 6. MDH will make this determination within the 90-day conditional license period. If MDH determines Bell Assisted Living LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Bell Assisted Living LLC's assisted living facility license, and Bell Assisted Living LLC will correct violations detected during the survey to come into full compliance. If MDH determines Bell Assisted Living LLC is not in substantial compliance, MDH may take additional enforcement action against Bell Assisted Living LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

RIGHTS AND WAIVERS:
Under this Stipulation, Bell Assisted Living LLC waives all hearing and reconsideration rights in Minn. Stat. § 144G.20 and Minn. Stat. § 144G.32 to dispute the referenced survey findings and the conditional assisted living facility license under the terms and duration noted above. Any pending requests for hearing or reconsideration related to these survey findings are rescinded. Bell Assisted Living LLC retains all applicable appeal rights outlined in Minn. Stat. Chapter 144G for any enforcement action not outlined in this agreement.

FINES RESCINDED:
Under this Stipulation, MDH rescinds the fines assessed in the January 21, 2026, letter concerning the follow-up survey completed on January 14, 2026. The rescinded fines include those associated with order numbers 0340, 0420, 0650, 0680, 0730, 0900, 0910, 0950, 0970, 1060, 1370, 1380, 1440, 1530, 1620, 1640, 1710 and 1730 totaling $8,500.00. The correction orders outlined in the January 21, 2026, State Form remain in effect. Upon execution of this Stipulation, MDH will issue an amended enforcement letter to the licensee, rescinding the fines.

BINDING EFFECT:
This Stipulation is binding upon the Parties, the licensee (including their employees and/or contractors), and representatives. The Parties will assure that their employees, agents, heirs, administrators, representatives, and executors, are made aware of this Stipulation.

NO LIMITED AUTHORITY:
This Stipulation does not in any way or manner limit or affect the authority of MDH to take additional enforcement action against Bell Assisted Living LLC based on any act, conduct, or admission of Bell Assisted Living LLC which justifies enforcement action and occurred either before or after the date of this Stipulation and which is not directly related to the facts and circumstances covered in this Stipulation.

ENTIRE AGREEMENT AND ENFORCEMENT:
Parties agree this stipulation and consent order contains the entire agreement between Bell Assisted Living LLC and MDH related to the survey and supersedes any prior written or oral settlement discussions or agreement between the parties related to violations contained in the enforcement letter.

MDH will provide a signed electronic copy of the Stipulation to Bell Assisted Living LLC. Noncompliance with this Stipulation may result in further enforcement action under 144G and/or the pursuit of further legal remedies available under the law.

Except when used to enforce the terms of this Stipulation, this Stipulation does not constitute nor involve in any way an admission of MDH or Bell Assisted Living LLC or of any fact or interpretation or law or rule.

DATA PRACTICES:
Parties agree that release of information from any Department file pertaining to this matter, including this agreement, is governed by the Minnesota Data Practices Act, Minn. Stat. ch. 13; the Official Records Act, Minn. Stat. §15.17; Minn. Stat. §144.051, and any other applicable law.

RIGHT TO COUNSEL AND ACKNOKWLEDGEMENT:
All parties acknowledge that they have been represented by counsel or have had the opportunity to retain counsel in this matter, have fully negotiated this Stipulation, and have not relied upon any statements by other parties, their employees, or agents in agreeing to this Stipulation.

EFFECTIVE DATE:
This Stipulation is effective upon the signature of the licensee and the MDH Commissioner or designee. As stated above, MDH will provide an electronic signed copy to Bell Assisted Living LLC once the appropriate MDH official has signed the document.

Bell Assisted Living LLC

Lensa. M

NAME, TITLE Lensa Mekonnen, Owner

Date: March 31, 2026

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

Rick Michals

Rick Michals, J.D., Executive Regional Operations Manager

Date: April 7, 2026

Electronically Delivered

January 21, 2026

Licensee
Bell Assisted Living LLC
11947 9th Avenue Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL37987016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 14, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0420 - 144g.40 Subdivision 1 - Responsibility For Housing And Services - $500.00
St - 0 - 0650 - 144g.42 Subd. 8 (a) - Staff Records - $500.00
St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness - $500.00

St - 0 - 0730 - 144g.43 Subd. 3 - Contents Of Resident Record - $500.00
St - 0 - 0900 - 144g.50 Subdivision 1 - Contract Required - $500.00
St - 0 - 0910 - 144g.50 Subd. 2 (a-B) - Contract Information - $500.00
St - 0 - 0950 - 144g.50 Subd. 3 - Designation Of Representative - $500.00
St - 0 - 0970 - 144g.50 Subd. 5 - Waivers Of Liability Prohibited - $500.00
St - 0 - 1060 - 144g.52 Subd. 9 - Emergency Relocation - $500.00
St - 0 - 1370 - 144g.61 Subd. 2 (a) - Training And Evaluation Of Unlicensed Personn - $500.00
St - 0 - 1380 - 144g.61 Subd. 2 (b) - Training And Evaluation Of Unlicensed Personn - $500.00
St - 0 - 1440 - 144g.62 Subd. 4 - Supervision Of Staff Providing Delegated Nurs - $500.00
St - 0 - 1530 - 144g.64 (a) (1-2) - Training In Dementia, Mental Illness
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $500.00
St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To - $500.00
St - 0 - 1710 - 144g.71 Subd. 3 - Individualized Medication Monitoring And Reas - $500.00
St - 0 - 1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $8,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Bell Assisted Living LLC. Please contact Kelly Thorson at 320-223-7336 **on or before Monday January 26, 2026**, to schedule the conference call.

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-800-337-9238 / 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	R 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37987016-2 On January 14, 2026, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 24, 2025. At the time of the survey, there were four (4) residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	{0 340}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	R 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

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{0 340}	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation and actions taken to comply with the correction orders from two surveys with the initial survey completed April 11, 2025, and a licensing order follow-up (LOF) survey compelted July 24, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a violation that harmed a resident's health or safety,	{0 340}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	R 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

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{0 340}	Continued From page 2 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 the residents). The findings include: On April 11, 2025, at 12:00 p.m., the licensee was provided an exit email related to the conclusion of the licensee's survey. The email was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and included a link posted on the Minnesota Department of Health's website for the Correction Order Documentation Guidelines document. On April 11, 2025, the licensee was provided an exit email related to the conclusion of the licensee's survey. The email was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and included a link posted on the Minnesota Department of Health's website for the Correction Order Documentation Guidelines document. On May 9, 2025, the licensee received the results of the survey concluded on April 11, 2025. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results. This date was May 30, 2025. On July 24, 2025, the licensee was provided an exit email related to the conclusion of the licensee's LOF survey. The email was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and included a link	{0 340}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 340}	Continued From page 3 posted on the Minnesota Department of Health's website for the Correction Order Documentation Guidelines document. On October 22, 2025, the licensee received the results of the survey concluded on July 24, 2025. A time period of correction is not issued when citations are re-issued as the licensee had surpassed the time period of correction from the initial survey. On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second LOF survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had started to use a computer software program to address issues for residents and had started to use an online training program for staff education but still had not fully corrected citations. No further information was provided.	{0 340}		
{0 420} SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident	{0 420}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

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{0 420}	Continued From page 4 for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective January 31, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and	{0 420}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	R 01/14/2026

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{0 420}	Continued From page 5 understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on January 20, 2025. On January 14, 2026, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated while licensee had created a plan of correction (POC) with the assistance of a consultant, the licensee had not fully implemented the POC. LALD/CNS-A stated the licensee would need to continue to address each citation and document actions taken to correct citations from previous surveys. As a result of this survey, the following orders were issued under 0340, 0420, 0650, 0680, 0730, 0900, 0910, 0950, 0970, 1060, 1370, 1380, 1440, 1530, 1620, 1640, 1710, and 1730 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided.	{0 420}		

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{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 a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts	{0 480}		

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{0 480}	Continued From page 7 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	{0 650}		

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{0 650}	Continued From page 8 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for four of four unlicensed personnel ((ULP)-B, ULP-C, ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant.	{0 650}		

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{0 650}	Continued From page 9 The POC read under the area titled 144G.42 Subd. 8 (a) Staff records, "LALD will update all employee records to ensure that they are complete. All future staff will have these items completed and documented as well." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had started to use an online training program for staff education and record storage but still had not corrected the citation for any ULP. No further information was provided.	{0 650}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	{0 680}		

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{0 680}	Continued From page 10 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: The licensee's undated EPP lacked documentation including all the required elements of: - annual review; -quarterly review of missing persons policy; and - use of volunteers, including the process/role for integration. On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF	{0 680}		

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{0 680}	Continued From page 11 survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.42 Subd. 10 Disaster planning and emergency preparedness, "LALD will complete annual review of EPP, and this will be scheduled on her calendar. She will review her missing resident policy quarterly during her QI meeting which will also be scheduled on her calendar. She will update her EPP to include use of volunteers, including the process/role for integration." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had not updated their EPP to include all required content and annual reviews of the plan. No further information was provided.	{0 680}		
{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;	{0 730}		

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{0 730}	Continued From page 12 (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 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.	{0 730}		

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{0 730}	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.43 Subd. 3 Contents of resident record, "LALD will audit client records and complete the following if they are missing." The document then had a copy of the statue with the list of required items to be included in the resident record. On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on	{0 730}		

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{0 730}	Continued From page 14 correcting citations from each previous survey. LALD/CNS-A stated the licensee had recently started using an online electronic health record (EHR) but had not collected and inputted the required information into each resident's respective record. No further information was provided.	{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:	{0 775}	Not reviewed during this survey.	
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.	

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{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	

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{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for four of four residents (R1, R2, R3, R4).	{0 900}		

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{0 900}	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.50 Subdivision 1 Contract required, "LALD will audit all client charts and complete a Residency Agreement if it is missing. All future admissions will include completion of a Residency Agreement. LALD has purchased Home Care Consultants manuals, and will use this paperwork." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased the Home Care Consultants manuals but had not implemented them nor obtained a signed contract	{0 900}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(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
{0 900}	Continued From page 18 from any resident. No further information was provided.	{0 900}		
{0 910} SS=F	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 14, 2026, at 8:00 a.m., the surveyor	{0 910}		

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{0 910}	Continued From page 19 initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.50 Subd. 2 (a-b) Contract information, "LALD will complete any missing information on all Residency Agreements for all current residents, specifically, the HFID. All future admissions will have a complete, signed, Residency Agreement prior to moving in. Updated Residency Agreement paperwork will be purchased from HCC (Home Care Consultants)." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased the Home Care Consultants manuals but had not implemented them nor obtained a signed contract from any resident. No further information was provided.	{0 910}		
{0 950} SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the	{0 950}		

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{0 950}	Continued From page 20 contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	{0 950}		

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{0 950}	Continued From page 21 or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.50 Subd. 3 Designation of representative, "LALD will not alter the Residency Agreement provided by HCC (Home Care Consultants). She will complete a new Designated Representative form for each resident, using the original document with the correct terminology. She will use this form for all future admissions, and purchase updates to manuals and forms as they become available." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased the Home Care Consultants manuals but had not implemented them nor obtained a signed contract from any resident. No further information was provided.	{0 950}		

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{0 970}	Continued From page 22	{0 970}		
{0 970} SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A	{0 970}		

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{0 970}	Continued From page 23 provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.50 Subd. 5 Waivers of liability prohibited, "Bell AL [assisted living] is using outdated manuals and forms. LALD will purchase updated manuals and forms from HCC (Home Care Consultants)." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased the Home Care Consultants manuals but had not implemented them nor obtained a signed contract from any resident. No further information was provided.	{0 970}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	{01060}		

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{01060}	Continued From page 24 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written notice with required content for an emergency relocation and when to notify the Office of Ombudsman for Long-Term Care of emergency relocation if one would occur. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01060}		

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{01060}	Continued From page 25 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.52 Subd. 9 Emergency relocation, "LALD will follow her Emergency Relocation policy going forward. 'in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: the resident, the resident's legal representatives, the resident's designated representatives, the resident's case manager and if the resident has been relocated and not returned to the facility within four days, the Office of Ombudsman for Long-Term Care.' This includes hospitalization." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased	{01060}		

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{01060}	Continued From page 26 the Home Care Consultants manuals but had not implemented them. No further information was provided.	{01060}		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy;	{01370}		

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{01370}	Continued From page 27 (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required training was completed for four of four unlicensed personnel ((ULP)-B, ULP-C, ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant.	{01370}		

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{01370}	Continued From page 28 The POC read under the area titled 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personnel, "LALD will assign Educare [an online training company] courses to all current and future ULP staff and perform competency testing." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had started to use an online training program for staff education and record storage but still had not corrected the citation for any ULP. No further information was provided.	{01370}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	{01380}		

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{01380}	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required training was completed for four of four unlicensed personnel ((ULP)-B, ULP-C, ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personnel, "CNS will perform training and competency testing on the following for all current and future ULP staff." The document then included a copy of the statue and areas the ULPs would be trained and competency tested.	{01380}		

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{01380}	Continued From page 30 On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had started to use an online training program for staff education and record storage but still had not corrected the citation for any ULP. No further information was provided.	{01380}		
{01440} SS=F	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 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	{01440}		

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{01440}	Continued From page 31 by: Based on interview and record review, the licensee failed to ensure required training was completed for four of four unlicensed personnel ((ULP)-B, ULP-C, ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.62 Subd. 4 Supervision of staff providing delegated nursing tasks, "CNS will perform supervisory visits for current ULP staff immediately, and then annually or sooner as needed thereafter. She will schedule supervisions of all new hires within 30 days of employment. She will use a calendar to ensure compliance with this requirement."	{01440}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	R 01/14/2026

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{01440}	Continued From page 32 On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had started to use an online training program for staff education and record storage but still had not corrected the citation for any ULP. No further information was provided.	{01440}		
{01530} SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed	{01530}		

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{01530}	Continued From page 33 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 employees received eight hours of initial dementia care training within the first 160 hours worked for two of four unlicensed personnel ((ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with	{01530}		

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{01530}	Continued From page 34 citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.64 Training in Dementia Care Required, "LALD will assign all current staff 8 hours of Dementia training in Educare immediately. All future hires will complete 8 hours of dementia training prior to working 160 hours." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had started to use an online training program for staff education and record storage but still had not corrected the citation for all ULPs. No further information was provided.	{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	{01620}		

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{01620}	Continued From page 35 executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	{01620}		

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{01620}	Continued From page 36 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) completed ongoing reassessment and monitoring every 90 days and failed to include required content from Minnesota Administrative Rules 4659.0150 Uniform Assessment Tool for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring, "CNS has received education on assessment timelines, and will follow them. She	{01620}		

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{01620}	Continued From page 37 will utilize a calendar to keep track of upcoming assessment due dates. She is now using RTasks/Residex [an online electronic health record] to complete comprehensive assessments." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased the online EHR system but the licensee had not started fully using the software. LALD/CNS-A stated the EHR would include all required content when fully utilized, but the licensee had only entered a couple items and was still learning how to use the system. No further information was provided.	{01620}		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	{01640}		

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{01640}	Continued From page 38 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan was developed for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.70 Subd. 4 (a-e) Service plan, implementation and	{01640}		

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{01640}	Continued From page 39 revisions, "LALD will develop service plans using RTasks [an online electronic health record (EHR)] and HCC (Home Care Consultants) paperwork, for all current and future residents." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased the online EHR system but the licensee had not started fully using the software. LALD/CNS-A stated the EHR would include all required content when fully utilized, but the licensee had only entered a couple items and was still learning how to use the system. No further information was provided.	{01640}		
{01710} SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for four of four residents (R1, R2, R3,	{01710}		

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{01710}	Continued From page 40 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.71 Subd. 3 Individualized medication monitoring and reassessment, "CNS will complete a medication assessment for all current residents. She will reassess at least annually." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased the online EHR system but the licensee had not started fully using the software. LALD/CNS-A stated the EHR would include all required content	{01710}		

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{01710}	Continued From page 41 when fully utilized, but the licensee had only entered a couple items and was still learning how to use the system. No further information was provided.	{01710}		
{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 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	{01730}		

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{01730}	Continued From page 42 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2026, at 8:00 a.m., the surveyor initiated the licensee's second licensing order follow-up (LOF) survey to ensure compliance with citations issued or re-issued on the first LOF survey completed on July 24, 2025. On January 14, 2026, at 9:48 a.m., LALD/CNS-A	{01730}		

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{01730}	Continued From page 43 provided the licensee's QI (quality improvement) Meeting minutes dated for October 30, 2025. LALD/CNS-A stated the document was the licensee's plan of correction (POC) that was developed with a registered nurse consultant. The POC read under the area titled 144G.71 Subd. 5 Individualized medication management plan, "CNS will develop a medication management plan for each current resident using RTasks/Residex [an online electronic health record (EHR)]. She will complete a medication management plan with each new admission." On January 14, 2026, at 11:30 a.m., LALD/CNS-A stated the licensee had not implemented the licensee's POC and was still working on correcting citations from each previous survey. LALD/CNS-A stated the licensee had purchased the online EHR system but the licensee had not started fully using the software. LALD/CNS-A stated the EHR would include all required content when fully utilized, but the licensee had only entered a couple items and was still learning how to use the system. No further information was provided.	{01730}		

Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

January 13, 2026

Licensee
Bell Assisted Living LLC
11947 9th Avenue Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL37987016

Dear Licensee:

Please Note: This notice amends the previous noticed dated October 22, 2025. Specifically, tags 0480, 0775, 0790 and 0810 have been removed, and the related fines rescinded, and the total amount subject to penalty assessment has been corrected. Further, your right to request a reconsideration or hearing has expired with the previous notice dated October 22, 2025. No other changes were made.

On July 24, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 11, 2025. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the April 11, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 11, 2025, found not corrected at the time of the July 24, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0420-Responsibility For Housing And Services-144g.40 Subdivision 1 - $500.00
0650-Staff Records-144g.42 Subd. 8 (a) - $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0730-Contents Of Resident Record-144g.43 Subd. 3 - $500.00
0910-Contract Information-144g.50 Subd. 2 (a-B)
0950-Designation Of Representative-144g.50 Subd. 3
0970-Waivers Of Liability Prohibited-144g.50 Subd. 5
1060-Emergency Relocation-144g.52 Subd. 9 - $500.00
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a) - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) - $500.00
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4 - $500.00
1530-Training In Dementia, Mental Illness, And De--144g.64 (a) (1-2) - $500.00
1610-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (a-B) - $500.00

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) - $500.00
1710-Individualized Medication Monitoring And Reas-144g.71 Subd. 3 - $500.00
1730-Individualized Medication Management Plan-144g.71 Subd. 5 - $500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - $500.00
1910-Disposition Of Medications-144g.71 Subd. 22 - $500.00

(Insert amount of fine to the right of the rule #, delete this note)

The details of the violations noted at the time of this follow-up survey completed on July 24, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on July 24, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0900-Contract Required-144g.50 Subdivision 1

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $9,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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

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

§ 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Kelly Thorson at 320-223-7336.

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

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Electronically Delivered

October 22, 2025

Licensee
Bell Assisted Living LLC
11947 9th Avenue Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL37987016

Dear Licensee:

On July 24, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 11, 2025. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the April 11, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 11, 2025, found not corrected at the time of the July 24, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0420-Responsibility For Housing And Services-144g.40 Subdivision 1 - $500.00
0480-Minimum Reqmts; Required Food Services-144g.41 Subdivision 1 Subd. 1a (a-B) - $500.00
0650-Staff Records-144g.42 Subd. 8 (a) - $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0730-Contents Of Resident Record-144g.43 Subd. 3 - $500.00
0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - $500.00
0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2-3) - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - $500.00
0910-Contract Information-144g.50 Subd. 2 (a-B)
0950-Designation Of Representative-144g.50 Subd. 3
0970-Waivers Of Liability Prohibited-144g.50 Subd. 5
1060-Emergency Relocation-144g.52 Subd. 9 - $500.00
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a) - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) - $500.00
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1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - $500.00
1910-Disposition Of Medications-144g.71 Subd. 22 - $500.00
(Insert amount of fine to the right of the rule #, delete this note)

The details of the violations noted at the time of this follow-up survey completed on July 24, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on July 24, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $500.00
0900-Contract Required-144g.50 Subdivision 1

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $11,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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

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CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

REQUESTING A HEARING

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

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We urge you to review these orders carefully. If you have questions, please contact Kelly Thorson at 320-223-7336.

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

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	R 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37987016-1 On July 24, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 11, 2025. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following orders were reissued and issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 340	Continued From page 1 (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed April 11, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level two violation (a	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	R 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 340	Continued From page 2 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 the residents). The findings include: On April 11, 2025, at 12:00 p.m., the licensee was provided an exit email related to the conclusion of the licensee's survey. The email was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and included a link posted on the Minnesota Department of Health's website for the Correction Order Documentation Guidelines document. On May 9, 2025, the licensee received the results of the survey concluded on April 11, 2025. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results. This date was May 30, 2025. On July 24, 2025, at 7:51 a.m., the surveyor initiated the licensee's revisit survey. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. No further information provided.	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	R 07/24/2025

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0 340	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 420} SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective January 31, 2025. The licensee's renewal "Application for Assisted	{0 420}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

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{0 420}	Continued From page 4 Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on January 20, 2025. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. As a result of this survey, the following orders were issued under 0340, 0420, 0480, 0650, 0660, 0680, 0730, 0775, 0790, 0810, 0900, 0910, 0950, 0970, 1060, 1370, 1380, 1440, 1530, 1610, 1620, 1640, 1710, 1730, 1760, and	{0 420}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 420}	Continued From page 5 1910 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 420}		
{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	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 480}	Continued From page 6 manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure,	{0 650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 650}	Continued From page 7 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 7, 2025, at 10:46 a.m., licensed assisted living director/	{0 650}	Not reviewed during this survey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(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
{0 650}	Continued From page 8 clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the required contents of the employee records. ULP-B began employment on July 13, 2024, to provide direct care services to residents. ULP-B's employee record lacked the following: - all records of orientation, infection control training, and competency evaluations - current job description including qualifications, responsibilities, and identification of the training needs - verification that required health screenings under subdivision 9 have taken place and the dates of those screenings - documentation of the background study as required under section 144.057 On April 7, 2025, at 2:07 p.m., LALD/CNS-A stated that there were several forms missing from the employee file. She stated she may have misplaced them. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Personnel Records policy dated February 1, 2022, indicated, at a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: - evidence of current professional licensure, registration or certification - results of background studies - records of annual training and infection control	{0 650}		

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	37987	A. BUILDING: _____ B. WING _____	R 07/24/2025

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{0 650}	Continued From page 9 training - documentation of orientation - documentation of supervision, as applicable - performance reviews - competency evaluations - signed job description - documentation of annual performance reviews identifying area of improvement needed and training needs No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{0 650}		
{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 maintain a tuberculosis (TB)	{0 660}		

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{0 660}	Continued From page 10 prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, and a completed health history and symptom screening for two of two employees (unlicensed personnel (ULP)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A), and an updated TB risk assessment for the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility's TB risk assessment was dated February 8, 2023, and the facility was determined to be a low risk level. The TB risk assessment was not reviewed annually. ULP-B ULP-B began employment on July 13, 2024, to provide direct care services to residents. ULP-B's record titled Individualized Immunization Compliance Report indicated QuantiFERON-TB Gold was completed on October 15, 2021, the	{0 660}		

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{0 660}	Continued From page 11 date was greater than 90 days prior to employment with the licensee. The record also lacked evidence a TB history and symptom screening was completed. LALD/CNS-A LALD/CNS-A began employment on January 1, 2021, to provide supervision and oversight to unlicensed personnel and provide direct services to residents. LALD/CNS-A's record lacked evidence a TB baseline screening to include either a TST or a blood test had been completed. The record also lacked evidence a TB history and symptom screening was completed. On April 8, 2025, at 9:20 a.m., LALD/CNS-A stated she had not updated the facility risk assessment recently and was not aware of the requirement to update annually. She stated they did not complete a TB screening for any of their employees. LALD/CNS-A stated she believed the facility was in compliance with TB testing and was unaware that they could not accept TB testing completed more than 90 days prior to employment. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's TB facility risk assessment dated February 8, 2023, indicated the TB risk assessment would be conducted or updated	{0 660}		

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{0 660}	Continued From page 12 annually and/or following risk of exposure. The licensee's Tuberculosis Screening / Prevention policy dated February 1, 2022, indicated [the facility] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: Risk Assessment, TB Screening, and Staff Education. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	{0 680}		

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{0 680}	Continued From page 13 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	{0 680}		

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{0 680}	Continued From page 14 portion or all the residents). The findings include: The licensee's undated EPP lacked documentation including all the required elements of: -annual review -quarterly review of missing persons policy - use of volunteers, including the process/role for integration On April 8, 2025, at 2:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware the EPP required annual review, or the missing resident policy required quarterly review. LALD/CNS-A stated she was not aware that it was missing any required content. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Emergency Preparedness policy dated February 1, 2022, indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated February 1, 2022, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly.	{0 680}		

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{0 680}	Continued From page 15 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{0 680}		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	{0 730}		

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{0 730}	Continued From page 16 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the resident record included all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee with a diagnosis of cerebrovascular accident (CVA) and started	{0 730}		

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{0 730}	Continued From page 17 receiving assisted living services on August 15, 2024. R1's Service Plan dated September 2, 2024, indicated R1 received services including meals, homemaking, medication administration, monthly vital sign monitoring and behavior management. R1's resident record lacked the following required content: - name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative - names, addresses, and telephone numbers of the resident's health and medical service providers - health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records - copies of guardianships, powers of attorney, or conservatorships - all records of communications pertinent to the resident's services - documentation that services have been provided as identified in the service plan - other documentation required under this chapter and relevant to the resident's services or status R2 R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's resident record lacked the following required content: - health information, including medical history,	{0 730}		

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{0 730}	Continued From page 18 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records - copies of any health care directives, guardianships, powers of attorney, or conservatorships - the facility's current and previous assessments and service plans - all records of communications pertinent to the resident's services - 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 - 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 -other documentation required under this chapter and relevant to the resident's services or status On April 9, 2025, at 10:07 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated many required documents are missing from the resident's chart. She stated, "I need to get better at that". On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. A policy was requested, however, not provided. No information was provided.	{0 730}		

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{0 730}	Continued From page 19 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:	{0 775}	Not reviewed during this survey.	
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	{0 810}		

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{0 810}	Continued From page 20 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	

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0 900	Continued From page 21	0 900		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of	0 900	Not reviewed during this survey.	

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0 900	Continued From page 22 one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted on August 9, 2024, with a diagnosis of schizoaffective disorder. R2 lacked a written contract. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 8, 2025, at 10:51 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 did not have a service agreement or assisted living contract. She stated she was aware of the requirements for an assisted living contract and a service agreement to be signed, prior to providing services to any resident. LALD/CNS-A stated, "I know I've missed a lot of stuff and need to get it done and improve." On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the	0 900		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(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
0 900	Continued From page 23 correction orders. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. LALD/CNS-A further stated a new admission (R3) was accepted on July 15, 2025, and they failed to complete a written contract. LALD/CNS-A stated, "I'm still working on it, they came last week". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1).	{0 910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 910}	Continued From page 24 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract was signed by R1 August 16, 2024. R1's contract did not include health facility identification (HFID) of the facility. On April 8, 2025, at 10:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware that the information was missing from R2's contract. She stated the same contract has been used for all residents, and she thought it was correct as they had received it from their assisted living consultant. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{0 910}		
{0 950} SS=C	144G.50 Subd. 3 Designation of representative	{0 950}		

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{0 950}	Continued From page 25 (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for two of two residents (R1, R2).	{0 950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 950}	Continued From page 26 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract was signed by R1 on December 5, 2024. R2 was not provided with an Assisted Living Contract at time of admission. R1's assisted living contract failed to include statute statement from 144.50 subd. 3 with required verbatim right to designate a representative for certain purposes' on a separate page in the contract. On December 17, 2024, licensed assisted living director (LALD)-B stated the designation of representative was changed in the assisted living contract for all resident's in November 2024. LALD-B stated she did not understand that it had to be verbatim per 144.50 subd. 3 when she updated the assisted living contract. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. No further information was provided.	{0 950}		

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{0 950}	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{0 950}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract included the following section which contained language waving the licensee's liability for health, safety, or	{0 970}		

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{0 970}	Continued From page 28 personal property of a resident: "INDEMNIFICATION: [the facility] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [the facility] harmless from any claims or damages unless caused solely by negligence of the [the facility]." On April 8, 2025, at 10:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the same contract has been used for all residents. LALD/CNS-A stated she believed the contract was correct as it was provided to her from the facilities assisted living consultant. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 970}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the	{01060}		

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{01060}	Continued From page 29 facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	{01060}		

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{01060}	Continued From page 30 licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 was admitted to the licensee and started receiving assisted living services on August 9, 2024. R2's record indicated R2 went to the emergency room on October 31, 2024, and was admitted. R2 returned to the licensee on November 5, 2024. R1's record lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider - contact information for the Office of Ombudsman for Long-Term Care - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	{01060}		

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{01060}	Continued From page 31 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On April 8, 2025, at 2:42 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the requirement and has not completed any emergency notifications. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Discharge and Transfer of Residents policy dated February 1, 2021, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: the resident, the resident's legal representatives, the resident's designated representatives, the resident's case manager and if the resident has been relocated and not returned to the facility within four days, the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01060}		

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{01370}	Continued From page 32	{01370}		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	{01370}		

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{01370}	Continued From page 33 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and, record review, the licensee failed to ensure required training was completed for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B had a hire date of July 13, 2024, and provided direct care services to residents. On April 8, 2025, at 3:10 p.m., the surveyor observed ULP-B provide meal/snack assistance to R2. ULP-B's employee record lacked documentation of all competencies to be completed by ULP including: -Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting -standby assistance techniques and how to perform them	{01370}		

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{01370}	Continued From page 34 On April 8, 2025, at 9:23 a.m., licensed assisted living direct/clinical nurse supervisor (LALD/CNS)-A provided a binder titled Skills Competency Evaluations for Home Health Aids. It contained blank, original competency forms. LALD/CNS-A stated she was aware of the competency requirements; however, she had not documented any competencies on ULP-B. She stated, "I fell off the wagon and need to do a lot of stuff". On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Staff Competency policy dated February 1, 2022, indicated the clinical nurse supervisor is responsible for the overall competency evaluation program. No one may provide direct care to residents on behalf of [the facility] before successfully passing the competency evaluation. The following documentation will be maintained related to competency evaluations: -facility name, location and license number -name of topic and methodology -date and total time -name/title of instructor and evaluator and a statement attesting that the employee successfully passed the training and -competency evaluation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01370}		

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{01380}	Continued From page 35	{01380}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed upon hire for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	{01380}		

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{01380}	Continued From page 36 ULP-B had a hire date of July 13, 2024, and provided direct care services to residents. On April 8, 2025, at 3:10 p.m., the surveyor observed ULP-B provide meal/snack assistance to R2. ULP-B's employee record lacked documentation of all competencies to be completed by ULP including: -reading and recording temperature, pulse, and respirations of the resident -safe transfer techniques and ambulation -range of motioning and positioning -administering medications or treatments as required -other registered nurse (RN)/professionally delegated tasks On April 8, 2025, at 9:23 a.m., licensed assisted living direct/clinical nurse supervisor (LALD/CNS)-A provided a binder titled Skills Competency Evaluations for Home Health Aids. It contained blank, original competency forms. LALD/CNS-A stated she was aware of the competency requirements however, she had not documented any competencies on ULP-B. She stated, "I fell off the wagon and need to do a lot of stuff". On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Staff Competency policy dated February 1, 2022, indicated the clinical nurse supervisor is responsible for the overall	{01380}		

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{01380}	Continued From page 37 competency evaluation program. No one may provide direct care to residents on behalf of [the facility] before successfully passing the competency evaluation. The following documentation will be maintained related to competency evaluations: -facility name, location and license number -name of topic and methodology -date and total time -name/title of instructor and evaluator and a statement attesting that the employee successfully passed the training and competency evaluation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01380}		
{01440} SS=F	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 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	{01440}		

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{01440}	Continued From page 38 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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B began employment on July 13, 2024, to provide direct care services to residents. ULP-B's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services.	{01440}		

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{01440}	Continued From page 39 On April 8, 2025, at 9:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided surveyor the April 2025, staff schedule. LALD/CNS-A stated ULP-B has been scheduled 40 hours per week since her date of hire and has worked unsupervised for all scheduled shifts following completion of her orientation. On April 8, 2025, at 2:37 p.m., LALD/CNS-A stated 30-day supervisions have not been completed on any unlicensed staff. LALD/CNS-A stated, "I should, but I haven't done any." On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Supervision of Unlicensed Staff policy dated February 1, 2022, indicated direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. The RN will document supervision in the employee's personnel file related to performance management. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01440}		
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the	{01530}		

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{01530}	Continued From page 40 following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under 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;	{01530}		

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{01530}	Continued From page 41 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B began employment on July 13, 2024, to provide direct care services to residents. ULP-B's orientation and training record lacked documentation of the required number of hours of dementia care training. The training record dated June 2024, included: -Dementia introduction and overview 1.0 (hours) -Dementia 4 Behaviors vs Symptoms 1.0 -Dementia 5 the Journey .75 On April 8, 2025, at 2:52 p.m., ULP-B stated she had completed all required dementia training. Surveyor and ULP-B reviewed the Educare (training program) transcript and ULP-B confirmed that eight (8) dementia courses were assigned to her. Three (3) were completed,	{01530}		

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{01530}	Continued From page 42 totaling 2.75 hours. ULP-B stated, "I forgot about it, it was me". On April 8, 2025, at 3:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had assigned the required eight (8) hours of dementia training in Educare for ULP-B to complete. LALD/CNS-A stated she did not follow-up to ensure all courses were completed. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Staff Orientation and Education policy dated February 1, 2022, indicated all direct care staff and supervisors providing direct services must receive training on dementia. (***See also dementia education.) Dementia Education Policy requested, however, it was not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01530}		
{01610} SS=F	144G.70 Subd. 2 (a-b) 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	{01610}		

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{01610}	Continued From page 43 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for two of two residents (R1, R2) receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee with a diagnosis of cerebrovascular accident (CVA) and started receiving assisted living services on August 15,	{01610}		

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{01610}	Continued From page 44 2024. R1's Service Plan dated September 2, 2024, indicated R1 required services including meals, homemaking, medication administration, monthly vital sign monitoring and behavior management. R1's record lacked an initial assessment. An admission assessment dated August 18, 2024, was completed three (3) days after the start of assisted living services. R2 R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's record lacked initial, admission, 14-day, 90-day and change of condition assessments. On April 8, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 and R2 lacked initial assessments prior to their move in dates. She stated she had not documented any nursing assessments on R2, but did complete them. "I know I've missed a lot of stuff and need to get it done and improve. I know the assessments are required". On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. LALD/CNS-A further stated a new admission (R3) was accepted on July 15,	{01610}		

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{01610}	Continued From page 45 2025, and they failed to complete an initial assessment prior to the date on which the prospective resident executed a contract with a facility or on the day R3 moved in. LALD/CNS-A stated, "I'm still working on it, they came last week". The licensee's Assessment and Reassessment policy dated February 1, 2022, indicated an individualized initial evaluation of all new residents will be completed by a registered nurse (RN) in order to develop a personalized service plan. The assessment shall be revised regularly and as appropriate. The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01610}		
{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	{01620}		

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{01620}	Continued From page 46 resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a 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	{01620}		

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{01620}	Continued From page 47 by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed ongoing reassessment and monitoring on or before days 14 and 90 and failed to use the uniform assessment tool for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on April 7, 2025, at 10:43 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the nurse completed assessments on admission, 14- day, and with any change in condition. R1 R1 was admitted to the licensee with a diagnosis of cerebrovascular accident (CVA) and started receiving assisted living services on August 15, 2024. R1's record included an initial assessment dated August 18, 2024, completed three (3) days after admission. A 14-day assessment dated September 3, 2024, completed two (2) days after the assessment was due. No additional assessments had been completed for 217 days. The assessments did not include all the required elements on the uniform assessment tool.	{01620}		

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{01620}	Continued From page 48 R2 R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked all nursing assessments. On April 8, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's record did not have any additional assessments following the 14-day assessment completed on September 3, 2024. She stated she had not documented any nursing assessments on R2 but had completed them. "I know I've missed a lot of stuff and need to get it done and improve. I know the assessments are required". LALD/CNS-A stated she did not know the uniform assessment tool used, lacked required information. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Assessment and Reassessment policy dated February 1, 2022, indicated an individualized initial evaluation of all new residents will be completed by a registered nurse (RN) in order to develop a personalized service plan. The assessment shall be revised regularly and as appropriate. The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier.	{01620}		

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{01620}	Continued From page 49 The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility must develop a uniform assessment tool to include all the required elements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}		

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{01640}	Continued From page 50 Based on observation, interview and record review, the licensee failed to ensure a service plan was developed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 8, 2025, at 9:43 a.m. surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provide medication administration for R2. On April 8, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 did not have a service plan. LALD/CNS-A stated she is aware of the requirements for a service plan to be signed, prior to providing services to any resident. LALD/CNS-A stated, "I know I've missed a lot of	{01640}		

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{01640}	Continued From page 51 stuff and need to get it done and improve." On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. LALD/CNS-A further stated a new admission (R3) was accepted on July 15, 2025, and they failed to complete a service agreement. LALD/CNS-A stated, "I'm still working on it, they came last week". The licensee's Service Plan policy dated February 1, 2022, indicated beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01640}		
{01710} SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.	{01710}		

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	37987	A. BUILDING: _____ B. WING _____	R 07/24/2025

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{01710}	Continued From page 52 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 9, 2025, at 9:43 a.m. surveyor observed LALD/CNS-A provide medication administration for R2. R2's record lacked a medication assessment. On April 8, 2025, at 10:51 a.m., licensed assisted	{01710}		

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{01710}	Continued From page 53 living director/clinical nurse supervisor (LALD/CNS)-A stated she had not documented any nursing assessments on R2, but did complete them. "I know I've missed a lot of stuff and need to get it done and improve. I know the assessments are required". On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Assessment of Medications policy dated February 1, 2022, indicated prior to providing medication management services, [the facility] will provide an assessment by a RN to determine what medication management services will be provided and how they will be implemented. The assessment includes all required elements. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{01710}		
{01730} SS=D	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	{01730}		

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{01730}	Continued From page 54 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional 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	{01730}		

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{01730}	Continued From page 55 review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 8, 2025, at 9:43 a.m. surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provide medication administration for R2. R2 lacked an individualized medication management record and all required content. On April 8, 2025, at 1:32 p.m., LALD/CNS-A stated she did not complete a medication assessment or individualized medication management for R2. LALD/CNS-A stated she	{01730}		

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{01730}	Continued From page 56 was aware of the requirements but did not complete them. She stated, "I know I've missed a lot of stuff and need to get it done and improve." On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Service Plan for Medication Management policy dated February 1, 2022, indicated [the facility] will prepare and document a Medication Management Plan as part of the Service Plan for each resident receiving medication management services. The registered nurse (RN) is responsible for preparing and documenting the Medication Management Plan. The Medication Management Plan will be kept current and updated with any changes. The RN will review the Medication Management Plan as part of the Service Plan with resident, the resident's designated representative and/or the resident's legal representative prior to implementation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{01730}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	{01760}		

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{01760}	Continued From page 57 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication administration was documented accurately and failed to ensure as needed (PRN) medications had documentation of administration and effectiveness for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted to the licensee with a diagnosis of cerebrovascular accident (CVA) and started receiving assisted living services on August 15, 2024. R1's Exhibit 2: Service Plan dated September 2, 2024, indicated R1 received services including meals, homemaking, medication administration,	{01760}		

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{01760}	Continued From page 58 monthly vital sign monitoring and behavior management. R1's record included an order for Methocarbamol 750 mg (milligrams), take 1 tablet by mouth every 8 hours as needed for muscle spasms, dated August 13, 2024. On April 9, 2025, at 10:00 a.m., the surveyor, along with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A observed the medication cabinet. The surveyor observed 2 (two) PRN medication cards labeled Methocarbamol 750 mg (milligrams), take 1 tablet by mouth every 8 hours as needed for muscle spasms. The first medication card was dated August 15, 2024, and had 26 tablets removed from the foil bubbles, with no remaining tablets in the medication card. The second medication card was dated September 12, 2024, and had 1 tablet removed from the foil bubble with 29 tablets remaining in the medication card. R1's October 2024, Medication Administration Record indicated the resident received the medication on October 11, 22, and 23, 2024. R1's Medication Administration Records for August, September, November, and December of 2024, and January through April of 2025, did not list the medication. 27 tablets were removed from the medication cards in total with only 6 tablets documented as given on R1's medication administration record. In addition, staff failed to document effectiveness of the PRN medication. R1's record lacked documentation of the medication, administration and effectiveness. R2	{01760}		

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{01760}	Continued From page 59 R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 9, 2025, at 9:43 a.m. surveyor observed LALD/CNS-A provide medication administration for R2. R2's record lacked a prescription order for Senna-Time 17.2 mg, take 2 tablets twice daily as needed for constipation. On April 9, 2025, at 10:00 a.m., the surveyor, along with LALD/CNS-A observed the medication cabinet. The surveyor observed 1 (one) PRN medication card labeled Senna-Time 17.2 mg, take 2 tablets twice daily as needed. The empty medication card was dated August 9, 2024, and had 30 tablets removed from the foil bubbles. R1's record lacked Medication Administration Records for August and September 2024. R1's Medication Administration Records for October 2024 through April 2025 indicated the medication was administered 1 time, on August 30, 2024. In addition, staff failed to document effectiveness of the PRN medication. R2's record lacked documentation of the medication, administration and effectiveness. On April 9, 2025, at 11:40 a.m., LALD/CNS-A stated staff does not document as needed	{01760}		

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{01760}	Continued From page 60 medication when they are given or the response to the medication. She stated, "we should, but we didn't, my charting is completely a mess and that is why I'm getting R-Tasks (Electronic Medical Record Program)." LALD/CNS-A stated she was aware of the requirements to include all prescribed medications on the Medication Administration Record, documenting the administration of all medications given and documenting the effectiveness of all PRN medications. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Medication Documentation policy dated February 1, 2022, indicated each medication administered by [the facility] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. Complete documentation of medication administration includes the following: a. Resident's name b. Medication name c. Medication dosage d. Date and time of administration e. Method/route of administration f. Signature and title of staff administering medications Documentation of medication administration and medication setup will be completed promptly. For PRN medications, documentation will include, when appropriate, the reason for the medication and follow-up to determine its effectiveness. No further information was provided.	{01760}		

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{01760}	Continued From page 61 TIME PERIOD FOR CORRECTION: Seven (7) days	{01760}		
{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 all required content for disposition of medications including expired, discontinued, wasted, and discharged resident medications. 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	{01910}		

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{01910}	Continued From page 62 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: During the entrance conference on April 7, 2025, at 10:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility and she follows policy and procedure for medication disposition. On April 8, 2025, at 10:57 a.m., surveyor verbally reviewed the facilities medication disposition process with LALD/CNS-A. LALD/CNS-A stated she destroys all expired and discontinued medications but does not document. She stated she was not aware of the requirements for medication disposition. On July 24, 2025, at 10:16 a.m., LALD/CNS-A stated due to staffing issues and personal reasons, they have not completed a plan of correction, nor have they corrected any of the correction orders. The licensee's Disposition and Disposal of Medications policy dated February 1, 2022, indicated, upon disposition, [the facility] will document the following information in the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity	{01910}		

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{01910}	Continued From page 63 c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{01910}		

Electronically Delivered

May 9, 2025

Licensee
Bell Assisted Living LLC
11947 9th Avenue Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL37987016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 11, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.0

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

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

The correction order documentation should include the following:

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

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

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

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

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

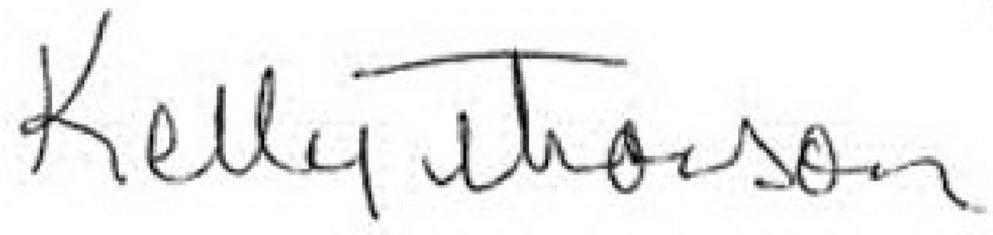
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER 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: SL#37987016 On April 7, 2025, through April 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 3 residents; 2 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420		

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective January 31, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the	0 420		

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0 420	Continued From page 2 provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on January 20, 2025. As a result of this survey, the following orders were issued under 0420, 0480, 0650, 0660, 0680, 0730, 0775, 0790, 0810, 0900, 0910, 0950, 0970, 1060, 1370, 1380, 1440, 1530, 1610, 1620, 1640, 1710, 1730, 1760, and 1910 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
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	0 480		

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

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0 480	Continued From page 4 (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 7, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 650	Continued From page 5	0 650		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 650		

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0 650	Continued From page 6 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 7, 2025, at 10:46 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the required contents of the employee records. ULP-B began employment on July 13, 2024, to provide direct care services to residents. ULP-B's employee record lacked the following: - all records of orientation, infection control training, and competency evaluations - current job description including qualifications, responsibilities, and identification of the training needs - verification that required health screenings under subdivision 9 have taken place and the dates of those screenings - documentation of the background study as required under section 144.057 On April 7, 2025, at 2:07 p.m., LALD/CNS-A stated that there were several forms missing from the employee file. She stated she may have misplaced them. The licensee's Personnel Records policy dated February 1, 2022, indicated, at a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: - evidence of current professional licensure, registration or certification	0 650		

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0 650	Continued From page 7 - results of background studies - records of annual training and infection control training - documentation of orientation - documentation of supervision, as applicable - performance reviews - competency evaluations - signed job description - documentation of annual performance reviews identifying area of improvement needed and training needs No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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:	0 660		

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0 660	Continued From page 8 Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, and a completed health history and symptom screening for two of two employees (unlicensed personnel (ULP)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A), and an updated TB risk assessment for the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility's TB risk assessment was dated February 8, 2023, and the facility was determined to be a low risk level. The TB risk assessment was not reviewed annually. ULP-B ULP-B began employment on July 13, 2024, to provide direct care services to residents. ULP-B's record titled Individualized Immunization Compliance Report indicated QuantiFERON-TB Gold was completed on October 15, 2021, the	0 660		

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0 660	Continued From page 9 date was greater than 90 days prior to employment with the licensee. The record also lacked evidence a TB history and symptom screening was completed. LALD/CNS-A LALD/CNS-A began employment on January 1, 2021, to provide supervision and oversight to unlicensed personnel and provide direct services to residents. LALD/CNS-A's record lacked evidence a TB baseline screening to include either a TST or a blood test had been completed. The record also lacked evidence a TB history and symptom screening was completed. On April 8, 2025, at 9:20 a.m., LALD/CNS-A stated she had not updated the facility risk assessment recently and was not aware of the requirement to update annually. She stated they did not complete a TB screening for any of their employees. LALD/CNS-A stated she believed the facility was in compliance with TB testing and was unaware that they could not accept TB testing completed more than 90 days prior to employment. The licensee's TB facility risk assessment dated February 8, 2023, indicated the TB risk assessment would be conducted or updated annually and/or following risk of exposure. The licensee's Tuberculosis Screening / Prevention policy dated February 1, 2022, indicated [the facility] will observe the recommended precautions related to TB prevention as identified by the Centers for	0 660		

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0 660	Continued From page 10 Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: Risk Assessment, TB Screening, and Staff Education. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to	0 680		

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0 680	Continued From page 11 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: The licensee's undated EPP lacked documentation including all the required elements of: -annual review	0 680		

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0 680	Continued From page 12 -quarterly review of missing persons policy - use of volunteers, including the process/role for integration On April 8, 2025, at 2:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware the EPP required annual review, or the missing resident policy required quarterly review. LALD/CNS-A stated she was not aware that it was missing any required content. The licensee's Emergency Preparedness policy dated February 1, 2022, indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated February 1, 2022, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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	0 730		

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0 730	Continued From page 13 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 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	0 730		

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	37987	A. BUILDING: _____ B. WING _____	04/11/2025

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0 730	Continued From page 14 status. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the resident record included all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee with a diagnosis of cerebrovascular accident (CVA) and started receiving assisted living services on August 15, 2024. R1's Service Plan dated September 2, 2024, indicated R1 received services including meals, homemaking, medication administration, monthly vital sign monitoring and behavior management. R1's resident record lacked the following required content: - name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative - names, addresses, and telephone numbers of the resident's health and medical service providers	0 730		

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0 730	Continued From page 15 - health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records - copies of guardianships, powers of attorney, or conservatorships - all records of communications pertinent to the resident's services - documentation that services have been provided as identified in the service plan - other documentation required under this chapter and relevant to the resident's services or status R2 R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's resident record lacked the following required content: - health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records - copies of any health care directives, guardianships, powers of attorney, or conservatorships - the facility's current and previous assessments and service plans - all records of communications pertinent to the resident's services - 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 - documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the	0 730		

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0 730	Continued From page 16 appropriate supervisor or health care professional -other documentation required under this chapter and relevant to the resident's services or status On April 9, 2025, at 10:07 a.m., licensed assisted living director/clinical nurse supervisor (LALD/ CNS)-A stated many required documents are missing from the resident's chart. She stated, "I need to get better at that". A policy was requested, however, not provided. No 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 and interview, the licensee failed to comply with the provisions of Minnesota State Fire Code under MN Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 775		

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0 775	Continued From page 17 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 7, 2025, at approximately 1:00 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The following was observed. SMOKING AREAS: Cigarette butts were observed on the ground of the designated smoking areas. The residents were not using the provided receptacle and discarding the cigarette butts onto the ground. Lighted matches, cigaretts, cigars or other burning objects shall not be discarded in such a maner that could cause ignition of other combustable materials. On April 7, 2025, LALD/CNS-A acknowledged the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 7, 2025, at approximately 1:00 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 19 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 20 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 7, 2025, at approximately 1:00 p.m., the surveyor observed the fire safety and evacuation plan (FSEP) did not include the fire evacuation diagrams. The fire evacuation diagrams were posted throughout the facility but were not present in the FSEP. On April 7, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire alarm systems. The policy indicated	0 810		

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0 810	Continued From page 21 staff shall "pull the alarm". The facility is not equipped with fire alarm pull stations. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have fire alarm systems. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On April 7, 2025, LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated staff were trained upon hire but failed to provide training to employees on the FSEP twice per year. No other training documentation was provided.	0 810		

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0 810	Continued From page 22 On April 7, 2025, LALD/CNS-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative	0 900		

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0 900	Continued From page 23 according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted on August 9, 2024, with a diagnosis of schizoaffective disorder. R2 lacked a written contract. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 8, 2025, at 10:51 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 did not have a service agreement or assisted living contract. She stated	0 900		

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0 900	Continued From page 24 she was aware of the requirements for an assisted living contract and a service agreement to be signed, prior to providing services to any resident. LALD/CNS-A stated, "I know I've missed a lot of stuff and need to get it done and improve." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 910		

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0 910	Continued From page 25 or has potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract was signed by R1 August 16, 2024. R1's contract did not include health facility identification (HFID) of the facility. On April 8, 2025, at 10:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware that the information was missing from R2's contract. She stated the same contract has been used for all residents, and she thought it was correct as they had received it from their assisted living consultant. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated	0 950		

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0 950	Continued From page 26 Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract was signed by R1 on December 5, 2024.	0 950		

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0 950	Continued From page 27 R2 was not provided with an Assisted Living Contract at time of admission. R1's assisted living contract failed to include statute statement from 144.50 subd. 3 with required verbatim right to designate a representative for certain purposes' on a separate page in the contract. On December 17, 2024, licensed assisted living director (LALD)-B stated the designation of representative was changed in the assisted living contract for all resident's in November 2024. LALD-B stated she did not understand that it had to be verbatim per 144.50 subd. 3 when she updated the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 970		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(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
0 970	Continued From page 28 contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract included the following section which contained language waving the licensee's liability for health, safety, or personal property of a resident: "INDEMNIFICATION: [the facility] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [the facility] harmless from any claims or damages unless caused solely by negligence of the [the facility]." On April 8, 2025, at 10:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the same contract has been used for all residents. LALD/CNS-A stated she believed the contract was correct as it was provided to her from the facilities assisted living consultant. No further information was provided.	0 970		

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0 970	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case	01060		

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01060	Continued From page 30 manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 was admitted to the licensee and started receiving assisted living services on August 9, 2024. R2's record indicated R2 went to the emergency room on October 31, 2024, and was admitted. R2 returned to the licensee on November 5, 2024. R1's record lacked a written notice including: - the name and contact information for the	01060		

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01060	Continued From page 31 location to which the resident has been relocated and any new service provider - contact information for the Office of Ombudsman for Long-Term Care - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On April 8, 2025, at 2:42 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the requirement and has not completed any emergency notifications. The licensee's Discharge and Transfer of Residents policy dated February 1, 2021, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: the resident, the resident's legal representatives, the resident's designated representatives, the resident's case manager and if the resident has been relocated and not returned to the facility within four days, the Office of Ombudsman for Long-Term Care. No further information was provided.	01060		

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01060	Continued From page 32 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's	01370		

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01370	Continued From page 33 family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and, record review, the licensee failed to ensure required training was completed for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B had a hire date of July 13, 2024, and provided direct care services to residents. On April 8, 2025, at 3:10 p.m., the surveyor observed ULP-B provide meal/snack assistance to R2. ULP-B's employee record lacked documentation of all competencies to be completed by ULP including: -Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting -standby assistance techniques and how to	01370		

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01370	Continued From page 34 perform them On April 8, 2025, at 9:23 a.m., licensed assisted living direct/clinical nurse supervisor (LALD/CNS)-A provided a binder titled Skills Competency Evaluations for Home Health Aids. It contained blank, original competency forms. LALD/CNS-A stated she was aware of the competency requirements; however, she had not documented any competencies on ULP-B. She stated, "I fell off the wagon and need to do a lot of stuff". The licensee's Staff Competency policy dated February 1, 2022, indicated the clinical nurse supervisor is responsible for the overall competency evaluation program. No one may provide direct care to residents on behalf of [the facility] before successfully passing the competency evaluation. The following documentation will be maintained related to competency evaluations: -facility name, location and license number -name of topic and methodology -date and total time -name/title of instructor and evaluator and a statement attesting that the employee successfully passed the training and -competency evaluation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380		

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01380	Continued From page 35 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed upon hire for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B had a hire date of July 13, 2024, and provided direct care services to residents. On April 8, 2025, at 3:10 p.m., the surveyor observed ULP-B provide meal/snack assistance	01380		

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01380	Continued From page 36 to R2. ULP-B's employee record lacked documentation of all competencies to be completed by ULP including: -reading and recording temperature, pulse, and respirations of the resident -safe transfer techniques and ambulation -range of motioning and positioning -administering medications or treatments as required -other registered nurse (RN)/professionally delegated tasks On April 8, 2025, at 9:23 a.m., licensed assisted living direct/clinical nurse supervisor (LALD/CNS)-A provided a binder titled Skills Competency Evaluations for Home Health Aids. It contained blank, original competency forms. LALD/CNS-A stated she was aware of the competency requirements however, she had not documented any competencies on ULP-B. She stated, "I fell off the wagon and need to do a lot of stuff". The licensee's Staff Competency policy dated February 1, 2022, indicated the clinical nurse supervisor is responsible for the overall competency evaluation program. No one may provide direct care to residents on behalf of [the facility] before successfully passing the competency evaluation. The following documentation will be maintained related to competency evaluations: -facility name, location and license number -name of topic and methodology -date and total time -name/title of instructor and evaluator and a statement attesting that the employee successfully passed the training and	01380		

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01380	Continued From page 37 -competency evaluation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	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 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 a registered nurse (RN) conducted direct supervision of staff performing a	01440		

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01440	Continued From page 38 delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B began employment on July 13, 2024, to provide direct care services to residents. ULP-B's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On April 8, 2025, at 9:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided surveyor the April 2025, staff schedule. LALD/CNS-A stated ULP-B has been scheduled 40 hours per week since her date of hire and has worked unsupervised for all scheduled shifts following completion of her orientation. On April 8, 2025, at 2:37 p.m., LALD/CNS-A stated 30-day supervisions have not been completed on any unlicensed staff. LALD/CNS-A stated, "I should, but I haven't done any."	01440		

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01440	Continued From page 39 The licensee's Supervision of Unlicensed Staff policy dated February 1, 2022, indicated direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. The RN will document supervision in the employee's personnel file related to performance management. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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	01530		

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01530	Continued From page 40 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B began employment on July 13, 2024, to provide direct care services to residents. ULP-B's orientation and training record lacked documentation of the required number of hours of dementia care training. The training record dated June 2024, included: -Dementia introduction and overview 1.0 (hours) -Dementia 4 Behaviors vs Symptoms 1.0 -Dementia 5 the Journey .75 On April 8, 2025, at 2:52 p.m., ULP-B stated she had completed all required dementia training. Surveyor and ULP-B reviewed the Educare (training program) transcript and ULP-B	01530		

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01530	Continued From page 41 confirmed that eight (8) dementia courses were assigned to her. Three (3) were completed, totaling 2.75 hours. ULP-B stated, "I forgot about it, it was me". On April 8, 2025, at 3:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had assigned the required eight (8) hours of dementia training in Educare for ULP-B to complete. LALD/CNS-A stated she did not follow-up to ensure all courses were completed. The licensee's Staff Orientation and Education policy dated February 1, 2022, indicated all direct care staff and supervisors providing direct services must receive training on dementia. (***See also dementia education.) Dementia Education Policy requested, however, it was not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=F	144G.70 Subd. 2 (a-b) 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	01610		

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01610	Continued From page 42 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for two of two residents (R1, R2) receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee with a diagnosis of cerebrovascular accident (CVA) and started receiving assisted living services on August 15, 2024. R1's Service Plan dated September 2, 2024, indicated R1 required services including meals, homemaking, medication administration, monthly	01610		

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	37987	A. BUILDING: _____ B. WING _____	04/11/2025

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01610	Continued From page 43 vital sign monitoring and behavior management. R1's record lacked an initial assessment. An admission assessment dated August 18, 2024, was completed three (3) days after the start of assisted living services. R2 R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's record lacked initial, admission, 14-day, 90-day and change of condition assessments. On April 8, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 and R2 lacked initial assessments prior to their move in dates. She stated she had not documented any nursing assessments on R2, but did complete them. "I know I've missed a lot of stuff and need to get it done and improve. I know the assessments are required". The licensee's Assessment and Reassessment policy dated February 1, 2022, indicated an individualized initial evaluation of all new residents will be completed by a registered nurse (RN) in order to develop a personalized service plan. The assessment shall be revised regularly and as appropriate. The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier.	01610		

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01610	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed ongoing reassessment and monitoring on or before days 14 and 90 and failed	01620		

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01620	Continued From page 45 to use the uniform assessment tool for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on April 7, 2025, at 10:43 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the nurse completed assessments on admission, 14- day, and with any change in condition. R1 R1 was admitted to the licensee with a diagnosis of cerebrovascular accident (CVA) and started receiving assisted living services on August 15, 2024. R1's record included an initial assessment dated August 18, 2024, completed three (3) days after admission. A 14-day assessment dated September 3, 2024, completed two (2) days after the assessment was due. No additional assessments had been completed for 217 days. The assessments did not include all the required elements on the uniform assessment tool. R2 R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024.	01620		

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01620	Continued From page 46 R2's record lacked all nursing assessments. On April 8, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's record did not have any additional assessments following the 14-day assessment completed on September 3, 2024. She stated she had not documented any nursing assessments on R2 but had completed them. "I know I've missed a lot of stuff and need to get it done and improve. I know the assessments are required". LALD/CNS-A stated she did not know the uniform assessment tool used, lacked required information. The licensee's Assessment and Reassessment policy dated February 1, 2022, indicated an individualized initial evaluation of all new residents will be completed by a registered nurse (RN) in order to develop a personalized service plan. The assessment shall be revised regularly and as appropriate. The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility must develop a uniform assessment tool to include all the required elements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 47 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a service plan was developed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01640		

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01640	Continued From page 48 The findings include: R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 8, 2025, at 9:43 a.m. surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provide medication administration for R2. On April 8, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 did not have a service plan. LALD/CNS-A stated she is aware of the requirements for a service plan to be signed, prior to providing services to any resident. LALD/CNS-A stated, "I know I've missed a lot of stuff and need to get it done and improve." The licensee's Service Plan policy dated February 1, 2022, indicated beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. No further information provided.	01640		

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01640	Continued From page 49 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's unlicensed personnel Charting Sheet dated April	01710		

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01710	Continued From page 50 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 9, 2025, at 9:43 a.m. surveyor observed LALD/CNS-A provide medication administration for R2. R2's record lacked a medication assessment. On April 8, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not documented any nursing assessments on R2, but did complete them. "I know I've missed a lot of stuff and need to get it done and improve. I know the assessments are required". The licensee's Assessment of Medications policy dated February 1, 2022, indicated prior to providing medication management services, [the facility] will provide an assessment by a RN to determine what medication management services will be provided and how they will be implemented. The assessment includes all required elements. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730		

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01730	Continued From page 51 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional 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	01730		

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01730	Continued From page 52 review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication administration, and behavioral management. On April 8, 2025, at 9:43 a.m. surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provide medication administration for R2. R2 lacked an individualized medication management record and all required content. On April 8, 2025, at 1:32 p.m., LALD/CNS-A stated she did not complete a medication assessment or individualized medication management for R2. LALD/CNS-A stated she was aware of the requirements but did not	01730		

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01730	Continued From page 53 complete them. She stated, "I know I've missed a lot of stuff and need to get it done and improve." The licensee's Service Plan for Medication Management policy dated February 1, 2022, indicated [the facility] will prepare and document a Medication Management Plan as part of the Service Plan for each resident receiving medication management services. The registered nurse (RN) is responsible for preparing and documenting the Medication Management Plan. The Medication Management Plan will be kept current and updated with any changes. The RN will review the Medication Management Plan as part of the Service Plan with resident, the resident's designated representative and/or the resident's legal representative prior to implementation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 54 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication administration was documented accurately and failed to ensure as needed (PRN) medications had documentation of administration and effectiveness for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted to the licensee with a diagnosis of cerebrovascular accident (CVA) and started receiving assisted living services on August 15, 2024. R1's Exhibit 2: Service Plan dated September 2, 2024, indicated R1 received services including meals, homemaking, medication administration, monthly vital sign monitoring and behavior management. R1's record included an order for Methocarbamol 750 mg (milligrams), take 1 tablet by mouth every 8 hours as needed for muscle spasms, dated August 13, 2024.	01760		

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01760	Continued From page 55 On April 9, 2025, at 10:00 a.m., the surveyor, along with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A observed the medication cabinet. The surveyor observed 2 (two) PRN medication cards labeled Methocarbamol 750 mg (milligrams), take 1 tablet by mouth every 8 hours as needed for muscle spasms. The first medication card was dated August 15, 2024, and had 26 tablets removed from the foil bubbles, with no remaining tablets in the medication card. The second medication card was dated September 12, 2024, and had 1 tablet removed from the foil bubble with 29 tablets remaining in the medication card. R1's October 2024, Medication Administration Record indicated the resident received the medication on October 11, 22, and 23, 2024. R1's Medication Administration Records for August, September, November, and December of 2024, and January through April of 2025, did not list the medication. 27 tablets were removed from the medication cards in total with only 6 tablets documented as given on R1's medication administration record. In addition, staff failed to document effectiveness of the PRN medication. R1's record lacked documentation of the medication, administration and effectiveness. R2 R2 was admitted to the licensee with a diagnosis of schizoaffective disorder and started receiving assisted living services on August 9, 2024. R2's record lacked a service plan. R2's unlicensed personnel Charting Sheet dated April 5, 2025, indicated R2 received services including meal assistance, medication	01760		

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BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

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01760	Continued From page 56 administration, and behavioral management. On April 9, 2025, at 9:43 a.m. surveyor observed LALD/CNS-A provide medication administration for R2. R2's record lacked a prescription order for Senna-Time 17.2 mg, take 2 tablets twice daily as needed for constipation. On April 9, 2025, at 10:00 a.m., the surveyor, along with LALD/CNS-A observed the medication cabinet. The surveyor observed 1 (one) PRN medication card labeled Senna-Time 17.2 mg, take 2 tablets twice daily as needed. The empty medication card was dated August 9, 2024, and had 30 tablets removed from the foil bubbles. R1's record lacked Medication Administration Records for August and September 2024. R1's Medication Administration Records for October 2024 through April 2025 indicated the medication was administered 1 time, on August 30, 2024. In addition, staff failed to document effectiveness of the PRN medication. R2's record lacked documentation of the medication, administration and effectiveness. On April 9, 2025, at 11:40 a.m., LALD/CNS-A stated staff does not document as needed medication when they are given or the response to the medication. She stated, "we should, but we didn't, my charting is completely a mess and that is why I'm getting R-Tasks (Electronic Medical Record Program)." LALD/CNS-A stated she was aware of the requirements to include all prescribed medications on the Medication Administration Record, documenting the administration of all medications given and documenting the effectiveness of all PRN	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 57 medications. The licensee's Medication Documentation policy dated February 1, 2022, indicated each medication administered by [the facility] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. Complete documentation of medication administration includes the following: a. Resident's name b. Medication name c. Medication dosage d. Date and time of administration e. Method/route of administration f. Signature and title of staff administering medications Documentation of medication administration and medication setup will be completed promptly. For PRN medications, documentation will include, when appropriate, the reason for the medication and follow-up to determine its effectiveness. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(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
01910	Continued From page 58 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 all required content for disposition of medications including expired, discontinued, wasted, and discharged resident medications. 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: During the entrance conference on April 7, 2025, at 10:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility and she follows policy and procedure for medication disposition.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37987	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL ASSISTED LIVING LLC	11947 9TH AVENUE NW COON RAPIDS, MN 55433

(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
01910	Continued From page 59 On April 8, 2025, at 10:57 a.m., surveyor verbally reviewed the facilities medication disposition process with LALD/CNS-A. LALD/CNS-A stated she destroys all expired and discontinued medications but does not document. She stated she was not aware of the requirements for medication disposition. The licensee's Disposition and Disposal of Medications policy dated February 1, 2022, indicated, upon disposition, [the facility] will document the following information in the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *04/07/25*
Time: 12:09:34
Report: 1029251095

Food and Beverage Establishment Inspection Report

Location:

Bell Assisted Living LLC
11947 9th Avenue
Coon Rapids, MN55433
Anoka County, 02

Establishment Info:

ID #: 0041109
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

2/28/23-4/7/25: NO EMPLOYEE ILLNESS LOG. NAVIGATED TO MDH WEBSITE DURING INSPECTION AND DOWNLOADED ILLNESS LOG. ILLNESS LOGGING, EXCLUSION, AND REPORTING REQUIREMENTS DISCUSSED.

Comply By: 04/07/25

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

BUTTER IN TOP PART OF DOOR IN DANGER ZONE: 43-47F. DISCARDED BY OPERATOR. OPERATOR INSTRUCTED TO ADJUST COOLER TO HAVE SAFE TEMPS THROUGHOUT AND TO NOT PLACE MORE TCS INTO TOP OF DOOR UNTIL SAFE TEMPS ARE VERIFIED THROUGHOUT.

Comply By: 04/07/25

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

HOUSE MADE PASTA SALAD MADE YESTERDAY W/OUT DATE MARK. DATE MARK REQUIRED ITEMS BUT DO NOT DATE MARK COMBINED ITEMS: ESTABLISHMENT HAS REQUIRED SAMEDAY SERVICE FOR COMBINED ITEMS.

Comply By: 04/07/25

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

PACKAGES OF SHREDDED CHEESE OPENED W/OUT DATE MARK. PACKAGES W/IN 7-DAY WINDOW. OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS.

Comply By: 04/07/25

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

2/28/23-4/7/25: NO CFPM. FOOD SAFETY COMPLETION CERTIFICATE FROM 2022 AWARDED TO LENSA MEKONNEN, PIC/LALD. INSTRUCTED OPERATOR TO EMPLOY INDIVIDUAL WITH UP-TO-DATE MN CFPM CERTIFICATION. CFPM ATTINMENT STEPS PROVIDED WITH REPORT.

Comply By: 02/28/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

HOUSE MADE PASTA SALAD IN COOLER FROM YESTERDAY. OPERATOR INSTRUCTED TO DISCARD AND TO NOT HOLD HOUSE MADE COMBINED ITEMS BEYOND SAMEDAY SERVICE WINDOW.

Comply By: 04/07/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

HANDWASHING NOTIFICATION SIGN ABSENT AT KITCHEN HANDWASHING SINK. HANDWASHING SIGN PROVIDED WITH REPORT.

Comply By: 04/07/25

Surface and Equipment Sanitizers

HOT WATER: = at >160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COLD HOLD/BUTTER
Temperature: 47 Degrees Fahrenheit - Location: REFRIGERATOR DOOR - UPPER
Violation Issued: Yes

Process/Item: COLD HOLD/BUTTER
Temperature: 43 Degrees Fahrenheit - Location: REFRIGERATOR DOOR - UPPER
Violation Issued: Yes

Process/Item: COLD HOLD/MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR DOOR - LOWER
Violation Issued: No

Process/Item: COLD HOLD/PASTA SALAD
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR CAVITY
Violation Issued: No

Process/Item: COLD HOLD/MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR CAVITY
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	2	3

Establishment residential in nature with same-day food service. Frigidaire high-temp sanitizing dishwasher present. Establishment uses min/max irreversible thermometer to log dishwasher sanitizing temperatures daily: 167-175F. Establishment has 3 clients some of which are part of a highly susceptible population. All identified issues discussed with operator in addition to food safety and foodborne illness risk factors.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029251095 of 04/07/25.

Certified Food Protection Manager: VACANT

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
LENSA MEKONNEN
LALD AND PIC

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957

Trevor McCliment

trevor.mccliment@state.mn.us

Food Establishment Inspection Report

Report #: 1029251095

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	5	**Date**	04/07/25
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:09:34
Legal Authority MN Rules Chapter 4626		**Time Out**	

Bell Assisted Living LLC	**Address** 11947 9th Avenue	**City/State** Coon Rapids, MN	**Zip Code** 55433	**Telephone**
License/Permit # 0041109	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water	COS	R
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 04/07/25

Inspector (Signature) Trevor McCliment