Electronically Delivered

October 16, 2025

Licensee
Anchor On Century
6292 Century Boulevard
Brooklyn Park, MN 55429

RE: Project Number(s) SL36788016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36788	A. BUILDING: _____ B. WING _____	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR ON CENTURY	6292 CENTURY BOULEVARD BROOKLYN PARK, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36788016-0 On September 2, 2025, through September 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 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 September 2, 2025, at 12:06 p.m., licensed assisted living director (LALD)-C stated one unlicensed personnel (ULP) worked each shift and the shift schedule was 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. On September 3, 2025, at 9:19 a.m., LALD-C provided a document titled [licensee] Direct Care Daily Staffing Schedule, with employee names for the month of September, and stated it was the licensee's staffing plan. The document lacked evidence the CNS had evaluated the staffing plan to ensure staffing levels were adequate to meet the residents' needs at least twice a year. On September 3, 2025, at 10:30 a.m., LALD-C stated they were responsible for ensuring there was coverage for each shift at the facility. LALD-C also stated they were unaware the staffing plan had to be evaluated twice a year by the CNS. Clinical nurse supervisor (CNS)-A was not available for interview. The licensee's undated, 4.06 Staffing & Schedule policy indicated the clinical nurse supervisor	0 470		

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0 470	Continued From page 3 would develop and implement a staffing plan that provides an adequate number of qualified staff to meet the residents needs 24-hours a day, seven days a week. The policy lacked guidance the CNS was required to evaluate the staffing plan at least twice a year. The Centers for Disease Control's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated use standard precautions to care for all patients in all settings. standard precautions include: - hand hygiene - environmental cleaning and disinfection - injection and medication safety - risk assessment with use of appropriate personal protective equipment (e.g., gloves, gowns, face masks) based on activities being performed - minimizing potential exposures (e.g. respiratory hygiene and cough etiquette) - reprocessing of reusable medical equipment between each patient or when soiled No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents:	0 480		

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0 480	Continued From page 4 (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; (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	0 480		

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0 480	Continued From page 5 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 September 2, 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		
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 6 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, at 1:30 p.m., the surveyor requested to review the licensee's infection prevention and control program.	0 510		

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0 510	Continued From page 7 On September 2, 2025, at 1:56 p.m., licensed assisted living director (LALD)-C provided the surveyor with the licensee's infection control policy and stated that was their infection prevention and control program. The licensee lacked written evidence of an infection prevention and control program with all the required content as outlined below: - leadership support; - education and training on infection prevention; - resident, family and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. On September 3, 2025, at 10:20 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare and administer medications to R2 in the dining area. When R2 picked the medication cup to take their medication, R2 accidentally dropped one pill on floor. ULP-B picked up the pill and wiped it with a paper towel and handed it to R2 who took the pill with a glass of apple juice. On September 3, 2025, at 11:00 a.m., ULP-B stated they should have called clinical nurse supervisor (CNS)-A or LALD-C to inform them of the incident and replace the pill for R2. On September 5, 2025, at 11:30 a.m., LALD-C stated all employees were trained to observe infection control precautions when handling resident medications. The licensee's Infection Control Policy dated January 6, 2023, indicated [licensee] will observe the recommended precautions for assisted living	0 510		

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0 510	Continued From page 8 as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those residents with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control. The policy lacked specific information for infection prevention and control program. The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated Core Practices should be implemented in all settings where healthcare is delivered including: - leadership support; - education and training on infection prevention; - resident, family and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
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	0 660		

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0 660	Continued From page 9 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 observation, 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 yearly facility TB risk assessment and assessing for current symptoms of active TB disease for two of two employees (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 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 facility TB risk assessment form dated May 22, 2022, indicated the facility was at a low risk for TB transmission. The licensee lacked a more	0 660		

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0 660	Continued From page 10 current facility TB risk assessment completed annually. The Minnesota Department of Health's (MDH) Assisted Living Resources and Frequently Asked Questions (FAQs) dated July 1, 2025, indicated each provider licensed by MDH is required to complete a TB risk assessment annually. ULP-B ULP-B started employment with the licensee on July 3, 2024, to provide assisted living services. ULP-B's record included a QuantiFERON TB gold plus dated July 11, 2024, which indicated ULP-B had a negative test result for TB. ULP-D ULP-D started employment with the licensee on May 23, 2024, to provide assisted living services. ULP-D's record included a QuantiFERON TB gold plus dated May 23, 2024, which indicated ULP-D had a negative test result for TB. ULP-B and ULP-D's record lacked an assessment for current symptoms of active TB disease. On September 5, 2025, at 11:40 a.m., licensed assisted living director (LALD)-C stated they could not explain how the assessment for current symptoms of active TB was missing in the employee record. LALD-C also stated the believed the records had been available during previous surveys. The licensee's most recent (follow-up) survey was completed April 2024, prior to the date of hire for ULP-B and ULP-D.	0 660		

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0 660	Continued From page 11 The licensee's Tuberculosis Screening/Prevention Policy dated January 6, 2023, indicated [licensee] will observe the recommended precautions related to TB prevention as identified by the CDC and the MDH. The precautions include the following elements. - risk assessment; - TB screening; and - staff education. The Minnesota Department of Health's (MDH) Assisted Living Resources and Frequently Asked Questions (FAQs) dated July 1, 2025, indicated Baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. 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;	0 680		

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	36788	A. BUILDING: _____ B. WING _____	09/05/2025

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0 680	Continued From page 12 (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 maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 September 2, 2025, at 11:20 a.m., the surveyor requested to review the licensee's	0 680		

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0 680	Continued From page 13 emergency preparedness plan (EPP). Licensed assisted living director (LALD)-C provided the surveyor with the licensee's EPP policy. When the surveyor pointed out what was provided was a policy and not an EPP, LALD-C stated the EPP binder was in their home and that they will bring it tomorrow. On September 3, 2025, at 9:30 a.m., the surveyor reminded LALD-C to provide the licensee's EPP. LALD-C stated they were still looking for it. However, by the survey exit time LALD-C had not provided their EPP. The licensee lacked an emergency disaster preparedness plan, with all the required content: - establishment of the EPP; - develop and maintain EPP; - maintain and annual EPP updates; - program patient population: identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - procedures for Tracking of Staff and Patients; - process for EPP collaboration; - development of EPP policies and procedures; - subsistence needs for staff and patients; - policies and procedures Including Evacuation; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a waiver declared by secretary; - arrangement with other Facilities; - development of communication plan; - names and contact information; - emergency officials contact information; - primary/alternate means for communication; - methods for Sharing information; - sharing information on occupancy/needs, and; - long-term care family notifications.	0 680		

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0 680	Continued From page 14 On September 3, 2025, at 3:29 p.m., LALD-C stated they purchased the EPP from a consultant company and believed it was misplaced either in the office or their home office. LALD-C stated they were still looking for the EPP to ensure it had required content. The licensee's Emergency Preparedness policy dated January 7, 2023, indicated licensee would 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

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0 780	Continued From page 15 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, at 9:15 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-C . During the tour, the surveyor observed when the wireless interconnected smoke alarms were tested the hardwired smoke alarms were not actuated. All dwelling unit smoke alarms must be interconnected so actuation of one alarm causes	0 780		

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0 780	Continued From page 16 all alarms in the dwelling unit to operate. During the facility tour interview, LALD-C verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar 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	0 810		

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0 810	Continued From page 17 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 and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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 September 2, 2025, at 10:47 a.m., licensed assisted living director (LALD)-C 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 FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency	0 810		

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0 810	Continued From page 18 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) and was very basic. The provided FSEP was a general guidance for fire response and included pulling the nearest fire alarm which this facility was not equipped for. Failed to have the fire safety plan, drills and training logs readily available at the time of the survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=D	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	01370		

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01370	Continued From page 19 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 (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 training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (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 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:	01370		

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01370	Continued From page 20 ULP-D started employment with the licensee on May 23, 2024, to provide assisted living services. ULP-D's record lacked evidence ULP-D had completed training and competency evaluations in the following areas: Competency - 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. Training - basic nutrition, meal preparation, food safety, and assistance with eating; and - preparation of modified diets as ordered by a licensed health professional. On September 3, 2025, at 3:37 p.m., licensed assisted living director (LALD)-C stated all employees received required training during orientation and before providing services to the licensee's residents. LALD-C also stated they needed to contact clinical nurse supervisor (CNS)-A as they thought the training competency was completed. No additional information had been provided by the survey exit time. The licensee's Unlicensed Personnel Training Policy dated January 6, 2023, indicated training and competency evaluations for all ULPs will include training on the missing topics above. No further information was provided.	01370		

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01370	Continued From page 21 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 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 interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (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 widespread scope (when	01380		

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01380	Continued From page 22 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B started employment with the licensee on July 3, 2024, to provide assisted living services. ULP-D ULP-D started employment with the licensee on May 23, 2024, to provide assisted living services. ULP-B and ULP-D's record lacked the following training and competency evaluations - recognizing physical, emotional, cognitive, and developmental needs of the resident. On September 3, 2025, at 3:37 p.m., licensed assisted living director (LALD)-C stated all employees received required training during orientation and before providing services to the licensee's residents. LALD-C also stated they needed to contact clinical nurse supervisor (CNS)-A as they thought the training competency was completed. No additional information had been provided by the survey exit time. The licensee's Competency Training Evaluations policy dated January 6, 2023, indicated training and competency evaluations for all ULPs will include training on recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01380		

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01380	Continued From page 23 (21) days	01380		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a),	01500		

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01500	Continued From page 24 annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (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 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).	01500		

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01500	Continued From page 25 The findings include: ULP-B ULP-B started employment with the licensee on July 3, 2024, to provide assisted living services. ULP-B's annual training transcript dated August 2025, indicated ULP-B had completed the following annual training topics for a total of 2.75 hours out of the required 8 hours: - Assisted Living Bill of Rights - 0.25 hours; - infection control techniques - 1.25 hours; and - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders - 1.25 hours. ULP-B's record lacked annual training in the following topics: - reporting maltreatment of vulnerable adults or minors; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. ULP-D ULP-D started employment with the licensee on May 23, 2024, to provide assisted living services. ULP-D's annual training transcript dated August 2025, indicated ULP-D had completed the following annual training topics for a total of 2 hours out of the required 8 hours: - Assisted Living Bill of Rights - 0.75 hours; and - infection control techniques - 1.25 hours. ULP-D's employee record lacked annual training	01500		

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	36788	A. BUILDING: _____ B. WING _____	09/05/2025

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01500	Continued From page 26 in the following topics: - reporting maltreatment of vulnerable adults or minors; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. On September 5, 2025, at 11:55 a.m., licensed assisted living director (LALD)-C stated all employees are assigned annual training at the same time of the year and that they expected everyone to have completed the training by this time. LALD-C also stated they had not audited their employee records to know who had not completed the annual training. The licensee's Annual Required Staff training policy dated January 6, 2023, indicated staff that perform direct care services at [licensee name] will complete at least eight hours of annual training for each 12 months of employment. The policy also indicated all the missing topics above will be covered during annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=D	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 27 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 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5) within 160 working hours of the employment start date. In addition, the licensee failed to ensure employees received required two hours of annual dementia training as required for one of two employees (unlicensed personnel (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 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: ULP-D started employment with the licensee on May 23, 2024, to provide assisted living services. ULP-D's training transcript dated between May 2024, and August 2025, indicated ULP-D had completed training in the following topics: - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse - 0.75 hours; - de-escalation techniques and communication -	01530		

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01530	Continued From page 29 0.50 hours; and - crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines - 0.75 hours. ULP-D's training transcript lacked initial dementia training on all the required topics including two hours annually: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On September 5, 2025, at 12:10 p.m., licensed assisted living director (LALD)-C stated they had forgotten to assign ULP-D their initial and annual dementia training as required. LALD-C also stated they had realized ULP-D lacked dementia training. The licensee's Dementia Education policy dated January 6, 2023, indicated direct care employees must have completed at least eight hours of initial education withing 160 working hours of the employment start date in the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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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. (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 the service plan, and any revisions included a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided 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, but was not likely to	01640		

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01640	Continued From page 31 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on June 3, 2025, to receive assisted living services. R1's undated service plan indicated R1 received the following services: housekeeping, behavior management, medication administration, and monitoring and assessments. R1's undated service plan was only signed by R1 but lacked a signature or other authentication by the facility. R2 R2 was admitted to the licensee on November 29, 2024, to receive assisted living services. R2's undated service plan indicated R2 received the following services: housekeeping, meal assistance, behavior management, medication administration, and monitoring and assessments. R2's undated service plan lacked a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. On September 5, 2025, at 11:48 a.m., licensed assisted living director (LALD)-C stated they thought the service plans were signed. LALD-C also stated they would check in their other folders	01640		

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01640	Continued From page 32 for service plans signed by both R1 and R2. By the time of survey exit LALD-C had not provided the surveyor with the said signed service plans. The licensee's Service Plan policy dated January 6, 2023, indicated the service plan will include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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 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	01730		

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01730	Continued From page 33 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 interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	01730		

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01730	Continued From page 34 situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on June 3, 2025, to receive assisted living services. R1's undated service plan indicated R1 received the following services: housekeeping, behavior management, medication administration, and monitoring and assessments. R1's individualized medication management plan (IMMP) dated June 25, 2025, indicated the following content: - type of medication storage system, based on resident's needs; - specific written instructions for resident's medication administration; and - medication management tasks that may be delegated to ULPs. R1's record and IMMP lacked the following content: - person responsible for monitoring medication supplies and refills. - procedures for staff to notify an RN when problems arose. On September 5, 2025, at 11:45 a.m., licensed assisted living director (LALD)-C stated they were not aware the IMMP was missing content. The surveyor tried to reach clinical nurse supervisor (CNS)-A for interview, but CNS-A was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01730		

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01730	Continued From page 35 days	01730		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written or electronically recorded prescription was maintained for all medications that the assisted living facility managed for the 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 on November 29, 2024, to receive assisted living services. R2's diagnoses included bipolar disorder, anxiety disorder, major depressive disorder, and history of traumatic brain injury (TBI). R2's undated service plan indicated R2 received	01820		

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01820	Continued From page 36 the following services: behavior management, medication administration, and monitoring and assessments. On September 3, 2025, at 10:20 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare and administer R2's morning medications. R2's medication administration record for the months of August 2025, and September 2025, indicated R2 received the following medications: certavite 25 milligram (mg) take one tablet by mouth daily, loratadine 10 mg take one tablet by mouth daily in the morning, metronidazole topical cream 0.75% apply to affected area (nose and cheek bones) twice daily, lorazepam 0.25 mg take one tablet by mouth at bedtime, melatonin 5 mg take one tablet by mouth at bedtime, mirtazapine 15 mg take one tablet by mouth at bedtime, olanzapine 20 mg take one tablet by mouth at bedtime, senna 8.6 mg - 50 mg take one tablet by mouth as needed, Advil 200 mg take two tablets by mouth as needed for pain, and polyethylene glycol 3350 take 17 grams (g) mixed with one cup of water every day as needed. R2's record lacked a current written or electronically recorded prescription for all medications the assisted living facility managed. On September 5, 2025, at 11:55 a.m., licensed assisted living director (LALD)-C stated they had sent a medication list through fax to the clinic for signature but they had not received them back. When the surveyor requested for the fax record, LALD-C stated they did not keep record of the faxes they sent.	01820		

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01820	Continued From page 37 The licensee's Medication Orders dated January 6, 2023, indicated the licensee will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted living Bill of Rights and in the Health Insurance Portability and Accountability Act. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01830		

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01830	Continued From page 38 The findings include: R1 was admitted to the licensee on June 3, 2025, to receive assisted living services. R1's diagnoses included borderline intellectual functioning, bipolar, depression, shortness of breath, and mild intermittent asthma. R1's undated service plan indicated R1 received the following services: housekeeping, behavior management, medication administration, and monitoring and assessments. R1's signed orders dated June 27, 2024, indicated R1 had the following medications: atorvastatin calcium 10 milligram (mg) take one tablet by mouth daily, dextroamphetamine 10 mg take one tablet by mouth twice a day, Inderal 20 mg take one tablet by mouth daily in the morning and at bedtime, lamotrigine 200 mg take one tablet by mouth daily, mirtazapine 15 mg take one tablet by mouth at bedtime, oxybutynin 10 mg take one tablet by mouth in the evening, pregabalin 150 mg take one tablet by mouth three times a day, zolpidem tartrate 10 mg take one tablet by mouth at bedtime, diclofenac sodium 1% gel apply 2-4 grams (g) topically 4 times a day as needed, ibuprofen 600 mg take one tablet by mouth every eight hours as needed, polyethylene glycol 17 g give one packet by mouth once daily as needed, and Ventolin Hfa 90 microgram (mcg) inhale two puffs by mouth four times daily as needed. R1's prescriptions were not renewed at least every 12 months or more frequently as indicated by the assessment in 144G.71 subdivision 2.	01830		

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01830	Continued From page 39 On September 5, 2025, at 11:55 a.m., licensed assisted living director (LALD)-C stated they had sent a medication list through fax to the clinic for signature but they had not received them back. When the surveyor requested for the fax record, LALD-C stated they did not keep record of the faxes they sent. The licensee's Medication Orders dated January 6, 2023, indicated the licensee will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted living Bill of Rights and in the Health Insurance Portability and Accountability Act. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of expired medications for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36788	A. BUILDING: _____ B. WING _____	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR ON CENTURY	6292 CENTURY BOULEVARD BROOKLYN PARK, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 40 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on June 3, 2025, to receive assisted living services. R1's undated service plan indicated R1 received the following services: behavior management, medication administration, and monitoring and assessments. On September 3, 2025, at 11:15 a.m., the surveyor observed the medication cabinet in R1's medication box and the following medications in were expired: - ibuprofen 600 milligram (mg) take one tablet by mouth as needed for pain - expired June 6, 2025; - mirtazapine 15 mg take one tablet by mouth at bedtime - expired June 24, 2025; - acetaminophen 500 mg two bottles - expired May 20, 2025, and June 24, 2025; - amoxicillin 125 mg take one tablet by mouth - no expiration dated; and - oxybutynin 10 mg er take one tablet by mouth - no expiration date. On September 5, 2025, at 11:40 a.m., licensed assisted living director (LALD)-C stated R1 was recently admitted and that they came with the medications. When the surveyor requested to know their protocol with expired medications, LALD-C stated the registered nurse audits the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36788	A. BUILDING: _____ B. WING _____	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR ON CENTURY	6292 CENTURY BOULEVARD BROOKLYN PARK, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 41 medication cabinet every month to take out expired medications. The licensee's Disposition and Disposal of Medications policy dated January 6, 2023, indicated discontinued medications may be kept until the expiration dates if there is a possibility of resuming the medication. If not resumed before the expiration date, it will be disposed of according to this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Food & Beverage Inspection Report

Establishment Info

Anchor On Century
6292 Century Boulevard
Brooklyn Park, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36788

Risk:
License:
Expires on:
CFPM: Benjamin Edison-Edebor
CFPM #: 56364; Exp: 2/16/2028

Inspection Info

Report Number: F7963251046
Inspection Type: Full - Single
Date: 9/2/2025 Time: 11:50:56 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-300 Personal Cleanliness

2-301.15 *Priority Level: Priority 2 CFP#: 8*

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.
COMMENT: KITCHEN IS EQUIPPED WITH A SINGLE BASIN SINK THAT IS BEING USED FOR BOTH HAND WASHING AND FOOD PREPARATION. REPLACING SINK WITH A TWO BASIN SINK WOULD BE ACCEPTABLE. CONTACT SANITARIAN IF YOU WOULD LIKE TO DISCUSS OTHER OPTIONS.
Comply By: 9/2/2026 Originally Issued On: 9/2/2025

New Order: 4-200 Equipment Design and Construction

4-201.11GMN *Priority Level: Priority 3 CFP#: 47*

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.
COMMENT: TCS FOODS FROM PREVIOUS DAYS FOUND IN REFRIGERATOR. SERVE ONLY FOODS MADE THE SAME DAY TO CLIENTS. NO COOLING OR RE-HEATING OF FOODS ALLOWED.
Comply By: 9/2/2025 Originally Issued On: 9/2/2025

Food & Beverage General Comment

MET WITH PERSON IN CHARGE BENJAMIN EDISON-EDEBOR AND MDH NURSE SURVEYOR BENARD NYANGENA.
DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS LOG AND POLICY
-REPORTABLE DISEASES
-DEFINITION OF SAME-DAY SERVICE
-SEPARATION OF SINKS FOR HAND WASHING AND FOOD PREPARATION
-THAWING OF FOOD
-DISCUSSED REQUIREMENTS FOR A HIGHLY SUSCEPTIBLE POPULATION

THIS IS A RESIDENTIAL HOME USING HOUSEHOLD APPLIANCES. ONLY SAME-DAY SERVICE OF FOOD IS ALLOWED (NO COOLING AND REHEATING OF LEFTOVER FOOD). A HOUSEHOLD DISHWASHER IS USED FOR WASHING AND SANITIZING DISHES.
THE KITCHEN HAS LAMINATE FLOORING, PAINTED WOOD CABINETS WITH A LAMINATE COUNTERTOP, PAINTED WALLS AND A POPCORN TEXTURED CEILING.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F7963251046 from 9/2/2025

Benjamin Edison-Edebor
PIC

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Anchor On Century
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F7963251046
Inspection Type: Full
Date: 9/2/2025
Time: 11:50:56 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:**
Location: KITCHEN REFRIGERATOR at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: LUNCH MEAT**; Temperature Process:**
Location: KITCHEN REFRIGERATOR at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:**
Location: BASEMENT REFRIGERATOR at 36 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Anchor On Century
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F7963251046
Inspection Type: Full
Date: 9/2/2025
Time: 11:50:56 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:**
Location: DISHWASHER RINSE **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No