



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

August 4, 2026

Licensee

Nordic Wood Assisted Living

14396 Grand Oaks Drive

Baxter, MN 56425

RE: Provisional Conditional License Number 418559
Health Facility Identification Number (HFID) 40897
Project Number(s) SL40897015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 10, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **November 2, 2026**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$2,000.00. **MDH is not imposing these fines against your provisional license at this time.**

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Nordic Wood Assisted Living a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90

calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Nordic Wood Assisted Living is in substantial compliance.

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

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. **No new admissions:** Nordic Wood Assisted Living will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. Nordic Wood Assisted Living must provide the Department:
 - i. A list of the names and birthdates of any individuals Nordic Wood Assisted Living is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Nordic Wood Assisted Living will contract with an RN to provide consultation concerning all resident(s) to whom Nordic Wood Assisted Living provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Nordic Wood Assisted Living. 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 Nordic Wood Assisted Living and MDH must review the RN’s credentials and approve the selection. Nordic Wood Assisted Living is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Nordic Wood Assisted Living in an effort to help Nordic Wood Assisted Living 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. Nordic Wood

Assisted Living 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 Nordic Wood Assisted Living and the RN consultant about a change. Each report will be electronically submitted to: **HRDConsultantReports.MDH@state.mn.us**. The content of the reports will include information such as:

 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Nordic Wood Assisted Living to correct the violations cited during the survey as well as to determine the overall practice of Nordic Wood Assisted Living 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 provisional 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 provisional license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.
- g. Corrective Action Plan:** Nordic Wood Assisted Living will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

 - i. A statement of the concern

- ii. A description of what will happen to correct the concern
- iii. A target date for when each correction will be complete
- iv. Who is responsible to make sure it happens
- v. Current status of correction work
- vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

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

MDH will determine if Nordic Wood Assisted Living is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Nordic Wood Assisted Living is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Nordic Wood Assisted Living. If MDH determines Nordic Wood Assisted Living is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

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 Jessie Chenze directly at: 218-332-5175 or email at: jessie.chenze@state.mn.us.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40897	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER NORDIC WOODS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 14396 GRAND OAKS DRIVE BAXTER, MN 56425		
(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 COMMENT SL40897016-0 On June 8, 2026, through June 10, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 20 residents; 20 receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on June 9, 2026, for tag identification 2310, issued at an isolated scope and level of three (G); the licensee took mitigating action, however, the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 470	Continued From page 2 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 held a provisional assisted living facility license effective November 27, 2024, and was licensed for a capacity of 20 residents, with a current census of 20 residents. During the entrance conference on June 8, 2026, at 9:24 a.m., owner (O)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with the current minimum assisted living license requirements. In addition, they stated they had three shifts as follows: - morning shift (6:00 a.m. to 2:30 p.m.) 3 unlicensed personnel (ULP); - evening shift (2:00 p.m. to 10:30 p.m.) 2 ULP, and (4:00 p.m. to 8:30 p.m.) 1 ULP; and - night shift (10:00 p.m. to 6:30 a.m.) 2 ULP. The licensee's untitled schedules from May 25, 2026, through June 14, 2026, included the employee names and total hours scheduled for the time period. However, it lacked a staffing plan with documented evidence of how the number of staff hours required was determined. On June 10, 2026, at 2:50 p.m., LALD/CNS-A stated she had reviewed the schedule on April 26, 2026, with O-F to see if they could decrease the number on the night shift but had no documented	0 470			

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0 470	Continued From page 3 evidence of this. LALD/CNS-A stated she had observed all shifts to see the ability to complete the tasks, the amount of time the pendants were pressed for assistance, and how long it took to answer them as part of this review. The licensee's Staffing & Scheduling policy dated January 12, 2025, noted the CNS would develop and implement a written staffing plan to provide an adequate number of direct-care staff to meet the residents' needs. Minnesota Administrative Rule 4659.0180, Subpart 3 dated August 11, 2021, indicated the clinical nurse supervisor must develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the clinical nurse supervisor must ensure that staffing levels were adequate to address the following: a. each resident's needs, as identified in the resident's service plan and assisted living contract; b. each resident's acuity level, as determined by the most recent assessment or individualized review; c. the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; d. whether the facility has a secured dementia care unit; and e. staff experience, training, and competency. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470			

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0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 550			

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0 550	Continued From page 5 The findings include: On June 8, 2026, at 10:15 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed the building to be a one level building with an entrance on two sides, with each side having resident rooms, a kitchen, dining room, common area, and offices. In the middle, was a large common area for resident/family and activity use. Postings were noted inside the main entrances. The complaint policy posted listed the name and telephone number of a previous LALD, and it lacked the name, telephone number, and email contact information for the current LALD/CNS, who was identified to be the individual responsible for handling resident grievances. On June 8, 2026, at 10:48 a.m., LALD/CNS-A stated she was the person responsible for handling resident grievances, and the posting had the incorrect information listed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630			

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0 630	Continued From page 6 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included diabetes mellitus type II, anxiety disorder, atherosclerotic heart disease, congestive heart failure, hypomagnesemia, hypertension, morbid obesity, atrial fibrillation, presence of a cardiac pacemaker, and weakness. On June 10, 2026, at 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with dressing after a shower and with medication administration.	0 630			

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0 630	Continued From page 7 R1's Service Plan dated December 4, 2025, indicated R1 received services including assistance with ambulation, bathing, compression stockings, dressing, mobility, and medication administration. R1's Assessment dated March 19, 2026, noted under vulnerability in the item column, "Resident is at risk to be abused (physically, verbally, emotionally, financially, and/or sexually), specify measures to minimize risk:" In the notes column it noted "Resident lives in a community setting for assisted living and is with other residents." Under the item column it also had "Resident is not at risk to abuse other vulnerable adults." Both rows were marked with a red V indicating a vulnerability. However, no statements of the specific measures to be taken to minimize the risk of abuse to that person or other vulnerable adults were noted. R2 R2's diagnoses included repeated falls, hypothyroidism, and atrial fibrillation (a rapid, irregular heartbeat). R2's Service Plan dated June 26, 2025, indicated R2 received services including assistance with bathing, compression stockings, dressing, and medication administration. R2's Assessment dated April 27, 2026, noted under vulnerability in the item column, "Resident is at risk to be abused (physically, verbally, emotionally, financially, and/or sexually), specify measures to minimize risk:" In the notes column it noted "Communal housing." Under the item column it also had "Resident has no known risk to abuse other vulnerable adults." Both rows were	0 630			

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0 630	Continued From page 8 marked with a red V indicating a vulnerability. However, no statements of the specific measures to be taken to minimize the risk of abuse to that person or other vulnerable adults was noted. On June 10, 2026, at 1:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the area was only marked due to living in an assisted living. LALD/CNS-A stated no interventions were noted and stated it was not individualized to the residents. The licensee's Individual Abuse Prevention Plan policy dated January 12, 2025, noted the plan would include the person's susceptibility to abuse by other individuals, the person's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=E	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 information: (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	0 650			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NORDIC WOODS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 14396 GRAND OAKS DRIVE BAXTER, MN 56425		
(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 9 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 observation, interview, and record review, the licensee failed to ensure the employee records contained the required content for three of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (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 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: During the entrance conference on June 8, 2026, at 9:24 a.m., LALD/CNS-A and owner (O)-B stated the licensee was aware of the required	0 650			

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0 650	Continued From page 10 content of the employee records. LALD/CNS-A LALD/CNS-A was hired on January 26, 2026, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. Throughout the survey, LALD/CNS-A was observed interacting with the licensee's residents. LALD/CNS-A's record included a job description for registered nurse (RN). However, it lacked a job description for her current position including: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-D ULP-D was hired on January 20, 2025, to provide direct care services to the licensee's residents. Throughout the survey, ULP-D was observed interacting with the licensee's residents. ULP-D's record included a job description. However, it lacked qualifications and identification of staff persons providing supervision. ULP-E ULP-E was hired on May 29, 2025, to provide direct care services to the licensee's residents. ULP-E's record lacked a job description including qualifications, responsibilities, and identification of staff persons providing supervision. On June 10, 2026, at 3:25 p.m., LALD/CNS-A stated she did not have a job description for her LALD/CNS position, and the employee job	0 650			

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0 650	Continued From page 11 descriptions were lacking the required content. The licensee's Employee Records policy dated January 12, 2025, noted employee records would include a current signed job description, including qualifications, responsibilities, and identification of supervisors, if any. 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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers	0 660			

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0 660	Continued From page 12 for Disease Control and Prevention (CDC), which included a current facility TB risk assessment. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 8, 2026, at 9:24 a.m., owner (O)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee's TB risk assessment was in the survey binder. The licensee's undated partial TB risk assessment included only page 11 and page 13, which lacked the designated and documented qualified person or team with the primary responsibility for the TB infection control program. On June 10, 2026, at 10:45 p.m., LALD/CNS-A stated she had not completed a TB risk assessment since she was hired on January 26, 2026, and this was the only TB documentation available from the previous CNS. The licensee's Tuberculosis Screening policy dated January 12, 2025, noted the licensee would maintain a current community TB risk assessment, updated annually.	0 660			

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0 660	Continued From page 13 The Minnesota Department of Health (MDH) 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680			

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0 680	Continued From page 14 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 8, 2026, at 10:15 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed the building to be a one level building with a main entrance on two sides, with each side having resident rooms, a kitchen, dining room, common area, and offices. In the middle, was a large common area for resident/family and activity use. The licensee's red binder labeled Disaster Manual was stamped as reviewed April 26, 2026. The EPP lacked the following required content: - quarterly review of the missing resident plan; - arrangements with other facilities/providers to receive residents in the event of	0 680			

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0 680	Continued From page 15 limitations/cessation of operations to maintain the continuity of services to residents; - policy/procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - EPP training at least annually; and - exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On June 10, 2026, at 3:40 p.m., LALD/CNS-A stated she had reviewed the missing resident plan in April with owner (O)-F, but had not documented it. It had been reviewed with staff in meetings, but that also was not documented. LALD/CNS-A also stated she was not aware of section 1135 being included in the plan, training on the plan was done on hire, but not annually, and no testing of the plan had been completed since she started working for the licensee on January 26, 2026. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated January 12, 2025, noted the plan would include all required elements of Appendix Z and would be reviewed annually. It also noted all staff would receive initial training and annual refresher training. The licensee's Missing Resident policy dated March 4, 2024, noted the licensee would review the policy at least quarterly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775			

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0 775	Continued From page 16 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 790 SS=C	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;	0 790			

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0 790	Continued From page 17 (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: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			

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0 800	Continued From page 18	0 800			
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			

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0 810 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: Based on observation, interview, and record	0 810			

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0 810	Continued From page 20 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810			
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	0 910			

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0 910	Continued From page 21 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 two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the facility on December 4, 2025. R1's Service Plan dated December 4, 2025, indicated R1 received services including assistance with ambulation, compression stockings, dressing, blood glucose checks, and medication administration. R1's Resident Agreement was signed by R1 on December 4, 2025. The agreement lacked the following required content: - current and accurate managing agent of the facility; and - licensee of the facility. R2 R2 admitted to the facility on February 18, 2025. R2's Service Plan dated June 26, 2025, indicated	0 910			

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0 910	Continued From page 22 R2 received services including assistance with bathing, compression stockings, dressing, and medication administration. R2's Resident Agreement was signed by R2 on February 19, 2026. The agreement lacked the following required content: - current and accurate managing agent of the facility; and - licensee of the facility. On June 10, 2026, at 3:05 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the managing agent listed was an old employee, and added the contract lacked the accurate name, phone number, and physical address of the managing agent and the licensee of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive	0 940			

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0 940	Continued From page 23 customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. 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 two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 940			

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0 940	Continued From page 24 R1 R1 admitted to the facility on December 4, 2025. R1's Service Plan dated December 4, 2025, indicated R1 received services including assistance with ambulation, compression stockings, dressing, blood glucose checks, and medication administration. R1's Resident Agreement was signed by R1 on December 4, 2025. The agreement lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program.	0 940			

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0 940	Continued From page 25 R2 R2 admitted to the facility on February 18, 2025. R2's Service Plan dated June 26, 2025, indicated R2 received services including assistance with bathing, compression stockings, dressing, and medication administration. R2's Resident Agreement was signed by R2 on February 19, 2026. The agreement lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On June 10, 2026, at 3:05 p.m., licensed assisted living director/clinical nurse supervisor	0 940			

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0 940	Continued From page 26 (LALD/CNS)-A stated the same contract was utilized for all residents, and lacked the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
01060 SS=D	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	01060			

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01060	Continued From page 27 be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R1) who was hospitalized. 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: R1's diagnoses included diabetes mellitus type II, anxiety disorder, atherosclerotic heart disease, congestive heart failure, hypomagnesemia, hypertension, morbid obesity, atrial fibrillation,	01060			

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01060	Continued From page 28 presence of a cardiac pacemaker, and weakness. R1's Service Plan dated December 4, 2025, indicated R1 received services including assistance with ambulation, bathing, compression stockings, dressing, mobility, and medication administration. R1's Resident Notes from January 24, 2026, through May 29, 2026, indicated R1 was sent to the hospital after a fall on January 24, 2026, and returned January 29, 2026. It also noted R1 was unable to be cared for at the facility and was hospitalized from February 3, 2026, through March 17, 2026. On June 10, 2026, at 1:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 had been hospitalized January 24, 2026, prior to her starting at the facility and no emergency relocation had been found for this hospitalization. In addition, CNS-A stated she had completed an emergency relocation for R1 on February 4, 2026, which was sent to the Ombudsman for Long-Term Care (OOLTC) and R1's daughter. However, the form had not been provided to the resident. The licensee's Emergency Relocation policy dated September 17, 2025, noted in the event of an emergency relocation, the licensee would provide a written notice to the resident, legal representative, designated representative, and OOLTC if the resident had been gone greater than four days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01060			

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01060	Continued From page 29 (21) days	01060			
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 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;	01370			

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01370	Continued From page 30 (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 as required prior to providing direct care services for one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated they were aware of the required contents of the employee records. ULP-E was hired on May 29, 2025, to provide direct care services to the licensee's residents. ULP-E's record lacked evidence of the following required training/competency testing: - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal	01370			

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01370	Continued From page 31 hygiene and grooming including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing, and assistance with toileting; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On June 10, 2026, at 3:35 p.m., LALD/CNS-A stated ULP-E was hired prior to her starting at the facility and she was unable to locate or state whether ULP-E had been trained on the above required content. LALD/CNS-A stated the expectation is staff are trained and tested to be competent prior to independently working with residents. The licensee's Training Records policy dated January 12, 2026, noted the licensee would document the training topic, date of training and competency evaluation, and the name and title of the instructor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			

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01380	Continued From page 32	01380			
01380 SS=D	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 as required prior to providing direct care services for one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01380			

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01380	Continued From page 33 During the entrance conference on June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated they were aware of the required contents of the employee records. ULP-E was hired on May 29, 2025, to provide direct care services to the licensee's residents. ULP-E's record lacked evidence of the following required training/competency testing: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to the appropriate personnel; - recognizing and recording temperature, pulse, and respirations of the resident; and - range of motion and positioning. On June 10, 2026, at 3:35 p.m., LALD/CNS-A stated ULP-E was hired prior to her starting at the facility and she was unable to locate or state whether ULP-E had been trained on the above required content. LALD/CNS-A stated the expectation is staff are trained and tested to be competent prior to independently working with residents. The licensee's Training Records policy dated January 12, 2026, noted the licensee would document the training topic, date of training and competency evaluation, and the name and title of the instructor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			

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01440	Continued From page 34	01440			
01440 SS=E	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 direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for two of two unlicensed personnel (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	01440			

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01440	Continued From page 35 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: During the entrance conference on June 8, 2024, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated they were aware of the required content of the employee records. ULP-D ULP-D was hired on January 20, 2025, to provide direct care services to the licensee's residents. Throughout the survey, the surveyor observed ULP-D interacting with the licensee's residents. ULP-D's record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. ULP-E ULP-E was hired on May 29, 2025, to provide direct care services to the licensee's residents. ULP-E's record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On June 10, 2026, at 3:25 p.m., LALD/CNS-A stated the employee records for ULP-D and ULP-E lacked evidence of a direct supervision. LALD/CNS-A said she would look in the electronic record to see if it was there from the	01440			

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01440	Continued From page 36 previous LALD. However, no further documentation was received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 37 other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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 orientation to assisted living requirements and regulations prior to providing services for two of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a	01470			

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01470	Continued From page 38 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: During the entrance conference on June 8, 2026, at 9:24 a.m., LALD/CNS-A and owner (O)-B stated the licensee was aware of the required content of the employee records. LALD/CNS-A LALD/CNS-A was hired on January 26, 2026, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. Throughout the survey, LALD/CNS-A was observed interacting with the licensee's residents. LALD/CNS-A's record lacked documented evidence of the following: - review of provider's policies and procedures; - handling emergencies and using emergency services; - handling of resident complaints, reporting of complaints, where to report complaints; and - review of the types of assisted living services the employee would provide and provider's scope of license. ULP-E ULP-E was hired on May 29, 2025, to provide direct care services to the licensee's residents.	01470			

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01470	Continued From page 39 ULP-E's record lacked documented evidence of the following: - assisted living Bill of Rights; and - review of provider's policies and procedures. On June 10, 2026, at 3:10 p.m., LALD/CNS-A stated she had not been trained by the previous CNS on these topics, and was not able to find evidence of the training for ULP-E. The licensee's Orientation of Staff and Supervisors & Content policy dated January 12, 2026, noted all employees must complete the orientation to the assisted living facility requirements prior to providing services to residents. It noted the orientation would include an introduction and review of the provider's policies and procedures, handling of emergencies and use of emergency services, assisted living Bill of Rights, handling of resident complaints, and a review of the types of assisted living services the employee would be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01480 SS=E	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced	01480			

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01480	Continued From page 40 by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-D and ULP-E) were oriented specifically to the licensee's 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 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: During the entrance conference on June 8, 2026, at 9:24 a.m., LALD/CNS-A and owner (O)-B stated the licensee was aware of the required content of the employee records. LALD/CNS-A LALD/CNS-A was hired on January 26, 2026, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. Throughout the survey, LALD/CNS-A was observed interacting with the licensee's residents. LALD/CNS-A's record lacked documented evidence of orientation to each individual resident and the services to be provided. ULP-D	01480			

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01480	Continued From page 41 ULP-D was hired on January 20, 2025, to provide direct care services to the licensee's residents. Throughout the survey, ULP-D was observed interacting with the licensee's residents. ULP-D's record lacked documented evidence of orientation to each individual resident and the services to be provided. ULP-E ULP-E was hired on May 29, 2025, to provide direct care services to the licensee's residents. ULP-E's record lacked documented evidence of orientation to each individual resident and the services to be provided. On June 10, 2026, at 3:10 p.m., LALD/CNS-A stated she had not been trained by the previous CNS on each individual resident and the services to be provided, and was not able to locate the training for ULP-D or ULP-E. The licensee's Orientation of Staff and Supervisors & Content policy dated January 12, 2026, noted staff providing services must be orientated specifically to each individual resident and the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500			

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01500	Continued From page 42 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), 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	01500			

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01500	Continued From page 43 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 annual training included all required topics for each 12 months of employment for two of three employees (unlicensed personnel/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 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: During the entrance conference on June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated they were aware of the	01500			

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01500	Continued From page 44 required content of the employee records. ULP-D ULP-D was hired on January 20, 2025, to provide direct care services to the licensee's residents. Throughout the survey, the surveyor observed ULP-D interacting with the licensee's residents. ULP-D's record included a transcript of training completed with dates ranging from January 20, 2025, through March 29, 2026. However, it lacked documented evidence of annual training including: - assisted living Bill of Rights; and - a review of the licensee's policies and procedures. ULP-E ULP-E was hired on May 29, 2025, to provide direct care services to the licensee's residents. ULP-E's record included a transcript of training completed with dates ranging from June 10, 2025, through April 15, 2026. However, it lacked documented evidence of annual training including: - assisted living Bill of Rights; and - a review of the licensee's policies and procedures. On June 10, 2026, at 3:25 p.m., LALD/CNS-A stated the employee records for ULP-D and ULP-E should have the above trainings included, but must not have been assigned to them. The licensee's Annual Required Staff Training policy dated January 12, 2026, noted training must be completed every 12 months including a review of the assisted living Bill of Rights and a	01500			

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01500	Continued From page 45 review of the licensee's policies and procedures related to the provision of care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
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 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	01530			

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01530	Continued From page 46 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 observation, interview, and record review, the licensee failed to ensure three of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-D, ULP-E) received the required amount of dementia care/mental illness training in the required time frame. 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: During the entrance conference on June 8, 2026, at 9:24 a.m., LALD/CNS-A and owner (O)-B stated the licensee was aware of the required content of the employee records.	01530			

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01530	Continued From page 47 The licensee held a provisional assisted living license effective November 26, 2024. LALD/CNS-A LALD/CNS-A was hired on January 26, 2026, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. Throughout the survey, LALD/CNS-A was observed interacting with the licensee's residents. LALD/CNS-A's record lacked documented evidence of: - two hours initial training related to mental illness and de-escalation. ULP-D ULP-D was hired on January 20, 2025, to provide direct care services to the licensee's residents. Throughout the survey, ULP-D was observed interacting with the licensee's residents. ULP-D's record lacked documented evidence of: - one hour annual training related to mental illness and de-escalation. ULP-E ULP-E was hired on May 29, 2025, to provide direct care services to the licensee's residents. ULP-E's record lacked documented evidence of: - one hour annual training related to mental illness and de-escalation. On June 10, 2026, at 3:10 p.m., LALD/CNS-A stated the mental illness and de-escalation training should be assigned through the electronic	01530			

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01530	Continued From page 48 training program, but had not been done for these three employees. The licensee's Dementia Training policy dated January 12, 2025, lacked instruction on the mental illness or de-escalation training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01565 SS=C	144G.64 (c) Training in Dementia, Mental Illness, and De- (a)The facility shall provide to consumers in written or electronic form a description of the training program, the categories of staff trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include the required content. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01565			

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01565	Continued From page 49 a large portion or all of the residents). The findings include: The licensee provided services under a provisional assisted living license effective November 27, 2024. The licensee's Dementia Training policy dated August 1, 2021, lacked the basic topic covered to include: - 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; - de-escalation techniques and communication; and - crisis resolution and suicide prevention, including procedures for contacting crisis response teams and 988 suicide and crisis lifelines. On June 10, 2026, at 2:47 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the policy lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01565			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an	01620			

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01620	Continued From page 50 initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must 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.	01620			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 51 (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment within the required timeframe 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's diagnoses included repeated falls, hypothyroidism, and atrial fibrillation (a rapid, irregular heartbeat). R2's Service Plan dated June 26, 2025, indicated R2 received services including assistance with bathing, compression stockings, dressing, and medication administration. R2's record contained the following: - Assessment dated January 22, 2026; and - Assessment dated April 27, 2026, (95 days after	01620			

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01620	Continued From page 52 the last assessment). On June 10, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the assessments are typically done within 90 days of the previous assessment, but this assessment was late. The licensee's Assessments, Reviews & Monitoring policy dated January 12, 2025, noted ongoing reassessments cannot exceed 90 calendar days from the date of the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650			

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01650	Continued From page 53 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included diabetes mellitus type II, anxiety disorder, atherosclerotic heart disease, congestive heart failure, hypomagnesemia, hypertension, morbid obesity, atrial fibrillation, presence of a cardiac pacemaker, and weakness. On June 10, 2026, at 6:45 a.m., the surveyor	01650			

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01650	Continued From page 54 observed unlicensed personnel (ULP)-C assist R1 with dressing after a shower and with medication administration. R1's Service Plan dated December 4, 2025, indicated R1 received services including assistance with ambulation, bathing, compression stockings, dressing, mobility, and medication administration. However, it lacked: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that included: - the action to be taken if the scheduled service cannot be provided. R2 R2's diagnoses included repeated falls, hypothyroidism, and atrial fibrillation (a rapid, irregular heartbeat). R2's Service Plan dated June 26, 2025, indicated R2 received services including assistance with bathing, compression stockings, dressing, and medication administration. However, it lacked: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that included: - the action to be taken if the scheduled service cannot be provided; and - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency.	01650			

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01650	Continued From page 55 On June 10, 2026, at 1:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1 and R2's service plans lacked the above required content, and added the same service plan was utilized for all residents. The licensee's Service Plan policy dated January 12, 2026, noted all residents receiving services would have a service plan which included: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that included: - the action to be taken if the scheduled service cannot be provided; and - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
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	01730			

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01730	Continued From page 56 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 57 review, the licensee failed to develop and implement a current individualized medication management plan to include all 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 situation has occurred only occasionally). The findings include: During the entrance conference on June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated the licensee provided medication management services to the licensee's residents. R1's diagnoses included diabetes mellitus type II, anxiety disorder, atherosclerotic heart disease, congestive heart failure, hypomagnesemia, hypertension, morbid obesity, atrial fibrillation, presence of a cardiac pacemaker, and weakness. On June 10, 2026, at 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with dressing after a shower and with medication administration. R1's Service Plan dated December 4, 2025, indicated R1 received services including assistance with ambulation, bathing, compression stockings, dressing, mobility, and medication	01730			

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01730	Continued From page 58 administration. R1's prescriber orders dated May 20, 2026, included insulin, a medication to assist with sleep, two medications to assist with anxiety, and a medication to assist with constipation. R1's record lacked a medication management plan including: - procedures for staff to notify the RN when problems arose; and - any resident-specific requirements. R1's Med (Medication) Admin (Administration) Summary for June 2026, instructed staff to notify nursing to inform the prescriber with blood sugar results between 351 to 400 milligrams/deciliter (mg/dL), and to notify the nurse to inform the physician with results of 451 mg/dL and above. However, the resident's record lacked instructions on what number to notify nursing of a low reading. On June 10, 2026, at 1:25 p.m., LALD/CNS-A stated the record lacked instructions for staff on any low readings, and this should be included. The licensee's Medication Management Individualized Plan policy dated January 12, 2025, noted a current individualized medication management plan must contain procedures for staff notifying the registered nurse when a problem arose and any resident-specific requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

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01780	Continued From page 59	01780			
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. 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: During the entrance conference on June 8, 2026, at 9:24 a.m., licensed assisted living	01780			

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01780	Continued From page 60 director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated the licensee provided medication management services to the licensee's residents. The licensee failed to develop a policy and procedure for giving accurate and current medications for residents having planned and unplanned times away from home. On June 10, 2026, at 2:45 p.m., LALD/CNS-A stated she did not find the policy online and would look for it. However, no policy was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790			

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01790	Continued From page 61 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790			

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01790	Continued From page 62 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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 June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated the licensee provided medication management services to the licensee's residents. The licensee failed to develop a policy and procedure for giving accurate and current medications for residents having planned and unplanned times away from home including written procedures including: - the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	01790			

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01790	Continued From page 63 - the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and - how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. On June 10, 2026, at 2:45 p.m., LALD/CNS-A stated she did not find the policy or procedure online and would look for it. However, no policy was provided.	01790			

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01790	Continued From page 64 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
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 date time-sensitive medications with an open date for one of two residents (R4) and failed to monitor for 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 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 June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	01890			

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01890	Continued From page 65 owner (O)-B stated the licensee provided medication management services to the licensee's residents. On June 8, 2026, at 11:40 a.m., the surveyor observed unlicensed personnel (ULP)-C administer insulin to R4. Upon completion, the following was noted: - R4's insulin aspart FlexPen (a pre-filled, disposable insulin pen) lacked a date when opened. On June 10, 2026, at 7:05 a.m., the surveyor observed ULP-C administer medications to R1 in his room. The surveyor then observed R1's insulin aspart FlexPen was marked as opened on April 29, 2026, and expired on May 27, 2026. After exiting R4's room, ULP-C took the insulin pen to LALD/CNS-A, who stated the insulin should not be administered after the expiration date and instructed ULP-C to dispose of the insulin pen. LALD/CNS-A also stated all insulin pens should be dated with an opened and expiration date. R1's prescriber orders dated May 20, 2026, included insulin aspart 100 unit/milliliter injection. Inject subcutaneously with meals per sliding scale: - 150-200 = 2 units; - 201-250 = 2 units; - 251-300 = 3 units; - 301-350 = 4 units; - 351-400 = 5 units and inform nursing. R1's Vital Sign - Blood Glucose record from March 8, 2026, through June 8, 2026, indicated R1's blood glucose was out of range 24 times, requiring a sliding scale dose of insulin from May 27, 2026, through June 8, 2026.	01890			

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01890	Continued From page 66 The manufacturer's instructions for use dated March 2023, noted the insulin was was good for 28 days after opened. The licensee's Medication Disposal policy dated January 12, 2025, noted expired medications would be disposed of. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	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	01910			

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01910	Continued From page 67 by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications with the required content for one of one resident (R5) upon discharge. 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 June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated the licensee provided medication management services to the licensee's residents. The licensee's Discharged or Deceased Resident Roster dated June 8, 2026, indicated R5 admitted to the facility on May 14, 2025, and discharged to another facility on February 25, 2026. R5's Service Plan dated June 26, 2025, indicated R5 received services including assistance with ambulation, grooming, dressing, and medication administration. R5's Discharge Nurse Note by LALD/CNS-A dated February 25, 2026, noted "Writer and staff gathered all medications, including ones received for new medication exchange today, and gave	01910			

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01910	Continued From page 68 them to daughter [name]." R5's record lacked documentation of medications to include: - medication name; - strength; - prescription number as applicable; and - quantity. On June 10, 2026, at 2:35 p.m., LALD/CNS-A stated they had not documented the disposition of medications with the required content. The licensee's Medication Disposal policy dated January 12, 2025, noted upon disposition, the licensee would document the medication name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940			

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01940	Continued From page 69 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized treatment and therapy management plan to include all 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 situation has occurred only occasionally). The findings include:	01940			

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01940	Continued From page 70 During the entrance conference on June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated the licensee provided treatment management services to the licensee's residents. R1's diagnoses included diabetes mellitus type II, anxiety disorder, atherosclerotic heart disease, congestive heart failure, hypomagnesemia, hypertension, morbid obesity, atrial fibrillation, presence of a cardiac pacemaker, and weakness. On June 10, 2026, at 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with dressing after a shower and with medication administration. R1's Service Plan dated December 4, 2025, indicated R1 received services including assistance with ambulation, bathing, compression stockings, dressing, mobility, and medication administration. R1's prescriber orders dated May 20, 2026, included insulin, a medication to assist with sleep, two medications to assist with anxiety, and a medication to assist with constipation. R1's record lacked a medication management plan including: - procedures for staff to notify the RN when problems arose; and - any resident-specific requirements. R1's Med (Medication) Admin (Administration) Summary for June 2026, instructed staff to notify nursing to inform the prescriber with blood sugar results between 351 to 400 milligrams/deciliter	01940			

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01940	Continued From page 71 (mg/dL), and to notify the nurse to inform the physician with results of 451 mg/dL and above. However, the resident's record lacked instructions on what number to notify nursing of a low reading. On June 10, 2026, at 1:25 p.m., LALD/CNS-A stated the record lacked instructions for staff on any low readings, and this should be included. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with hospital-style bed rails, and for one of one resident (R1) with consumer bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or	02310			

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02310	Continued From page 72 a limited number of staff are involved or the situation has occurred only occasionally). This practice resulted in an immediate order for correction on June 9, 2026. The findings include: HOSPITAL BED RAILS On June 9, 2026, at 11:45 a.m., the surveyor observed R3 in her hospital bed with bilateral bed rails in the raised position. R3's diagnoses included hypertension (high blood pressure), hypomagnesemia, anemia, asthma, syncope, major depressive disorder, pressure injury to the coccyx/buttocks. R3's Service Plan dated April 20, 2026, indicated R3 received services including assistance with ambulation, dressing, incontinence care, behavior monitoring, and medication management. R3's Assessment dated June 4, 2026, noted R3 was on hospice, unable to ambulate, able to modify positioning and staff to assist with repositioning from side to side every three hours. It noted resident did not transfer at that time, required assistance with changing of incontinence brief, had a history of anxiety, orientation was severely impaired, no pain reported, and was a fall risk. In addition, under bed safety, noted resident had an electric bed and "Managed by hospice - hospice agency vendor." On June 9, 2026, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated she was not aware R3 had a bed rail prior and stated she believed hospice must have provided it, possibly per request of the family, but she was not sure. R3	02310			

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02310	Continued From page 73 had a regular bed prior and staff were having difficulty assisting R3 with cares, so a hospital bed was requested from hospice. CNS-A stated she believed it came last week and was not there when she did her assessment on June 4, 2026. CNS-A stated an assessment should have been done with the new bed rail. On June 9, 2026, at 12:07 p.m., the surveyor observed CNS-A measure R3's bed rail. R3's bed rail was a brown metal with eight vertical bars between the edges of the bed rail, which ranged from 2 1/8 inches to 3 1/8 inches for zone 1 (within the rail), zero inches for zone 2 (under the rail, between the rail supports or next to a single rail support) zero inches for zone 3 (between the rail and the mattress) and zero inches for zone 4 (under the rail, at the ends of the rail). On June 9, 2026, at 12:40 p.m., unlicensed personnel (ULP)-D stated R3 got the bed rail a couple weeks ago. She said staff are to notify nursing if they notice a new device, but she had not reported it and believed someone else might have reported it to nursing. On June 9, 2026, at 1:05 p.m., CNS-A stated hospice delivered the bed and bed rail on May 27, 2026, and it should have been included on her assessment after that date. R3's record lacked a comprehensive assessment of the hospital-style bed rails to include whether the bed rail was considered an improper restraint, measurements, documentation the bed rail was securely attached per manufacturer recommendations, risk versus benefits, condition / description of the bed rail, purpose / intent of the bed rail, physical inspection of the bed rail and mattress for areas of entrapment, stability, and	02310			

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02310	Continued From page 74 correct installation, resident preferences, the condition and description of the device, resident preferences, and any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. In addition, it lacked documentation the bed rails were FDA compliant. CONSUMER RAILS R1's diagnoses included diabetes mellitus type II, anxiety disorder, atherosclerotic heart disease, congestive heart failure, hypomagnesemia, hypertension, morbid obesity, atrial fibrillation, presence of a cardiac pacemaker, and weakness. R1's Service Plan dated December 4, 2025, indicated R1 received services including assistance with ambulation, bathing, compression stockings, dressing, mobility, and medication administration. R1's Assessment dated March 19, 2026, noted R1 required assistance with dressing, ambulated with the wheelchair, required no assistance with bed mobility, and required transfer with assistance of one staff. It noted no pain reported. Under bed safety, it noted "Has one bed rail on his bed. This is to assist with bed mobility, while he is experiencing higher levels of pain while he rehabilitates his neck and back." It also noted zone 1 (the area within the rail) was less than 4 3/4 inches. The assessment also indicated R1 was a fall risk. On June 9, 2026, at 8:45 a.m., CNS-A stated the licensee did not have the manufacturer instructions for the consumer bed rail and had not checked the Consumer Product Safety Commission (CPSC) to see if the bed rail had been recalled.	02310			

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02310	Continued From page 75 On June 9, 2026, at 12:20 p.m., the surveyor observed R1's consumer bed rail with CNS-A. R1 was in his room in the recliner. R1's consumer bed rail was a white metal device with a black grip material across the top upside-down U-shaped piece and two black legs. There were two horizontal bars between the rail, and the feet went to the floor. In the middle, was a black metal piece that went between the mattress and box spring on the bed, with a strap attached to the middle of the outer edge of this piece which was wrapped around the bed frame and clasped in the middle of the bed between the mattress and box spring. The label noted the manufacturer was Hong Kong Pishon Medical Equipment, with model numbers H3-BK, H3-BL, and H3-GR noted. R1's record lacked a comprehensive assessment of the consumer bed rail to include whether the bed rail was considered an improper restraint, risk versus benefits, manufacturer guidelines, documentation that CPSC had been checked for recall, the condition and description of the device, and the resident's preferences. The licensee's Side Rails policy dated January 12, 2025, noted when in use, the registered nurse must conduct an assessment to identify the intended purpose, risks, and whether the rail is acting as a restraint. It noted the rail should be used according to manufacturer recommendations, ensure the rails are installed securely, and is consistent with the Food and Drug Administration (FDA) measurements to reduce entrapment. The Minnesota Department of Health (MDH) website, Assisted Living Resources &	02310			

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02310	Continued From page 76 Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When	02310			

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02310	Continued From page 77 bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a process in place to respond to and resolve resident grievances. 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	02480			

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02480	Continued From page 78 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 8, 2026, at 9:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner (O)-B stated the complaint procedure included forms being at each doorway a resident or family member could fill out and turn in or place in an envelope, communicate the complaint verbally to be relayed to herself or O-B. In addition, LALD/CNS-A and O-B stated the only complaint they had was about the internet not working, which has been resolved. On June 8, 2026, at 12:45 p.m., R4 spoke with the surveyor about the following concerns which she had expressed to LALD/CNS-A: - heating and cooling concerns in the building, with some rooms being very warm and some being very cold; - privacy concerns, with staff talking in front of residents about other residents private business; - security lights in the parking lot went out and have not been replaced, so it is very dark at night when residents can go outside if they want to; - doors not always being locked at night; - the facility not having an automatic door opener for residents who have difficulty getting in or out independently while trying to get through the door; - small print on documents for residents which is very difficult for some to read; - no closed captioning and talking behind residents with difficulty hearing; - the licensee's brochure says "Dining with table service and chef prepared meals". However, most are processed foods; and - internet not working, which she stated has been	02480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40897	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER NORDIC WOODS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 14396 GRAND OAKS DRIVE BAXTER, MN 56425			
(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
02480	Continued From page 79 resolved. On June 9, 2026, at 8:25 a.m., LALD/CNS-A stated she was aware of these concerns and stated they were being worked on. However, she stated she has not documented any of the complaints brought to her other than the internet. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02480			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Nordic Wood Assisted Living
14396 Grand Oaks Drive
Baxter, MN 56425
Crow Wing County
Parcel:

Phone:
nordicwoodassistedliving@gmail.com

License Info

License: HFID 40897

Risk:
License:
Expires on:
CFPM: Christopher Rosso
CFPM #: ; Exp: 4/8/2029

Inspection Info

Report Number: F6808261057
Inspection Type: Full - Joint
Date: 6/8/2026 Time: 11:00:39 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

DISCUSSION: EMPLOYEE ILLNESS LOG, PASTEURIZED EGG USE

DISHWASHER FINAL RINSE TEMPERATURE WAS VERIFIED TO BE AT LEAST 160 DEGREES.

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 St Cloud District Office inspection report number F6808261057 from 6/8/2026

Lee Ann Austin

Establishment Representative

Lee Ann Austin,
Public Health Sanitarian 3
320-223-7341
lee.ann.austin@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

Nordic Wood Assisted Living
Baxter
County/Group: Crow Wing County

Inspection Info

Report Number: F6808261057
Inspection Type: Full
Date: 6/8/2026
Time: 11:00:39 AM

Food Temperature: **Product/Item/Unit:** BBQ PORK; **Temperature Process:** Hot-Holding

Location: Steam Table at 146 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 37 Degrees F.

Comment: MAIN KITCHEN

Violation Issued?: No

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

Location: Upright Cooler at 34 Degrees F.

Comment: STORAGE KITCHEN

Violation Issued?: No



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Nordic Wood Assisted Living
Baxter
County/Group: Crow Wing County

Inspection Info

Report Number: F6808261057
Inspection Type: Full
Date: 6/8/2026
Time: 11:00:39 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Cook Line **Equal To** 400 PPM

Comment:

Violation Issued?: No

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

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

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL40897015-0	Date: 6/9/2026
Facility Name: NORDIC WOOD ASSISTED LIVING	
Facility Address: 14396 Grand Oaks Drive; Baxter MN 56425	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: Fire rated doors that are used to access the "Link" were propped open. Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency.

3. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

Comments: Multiple adaptors, unfused plugs, and other non-compliant electrical accessories were observed throughout the facility, including in staff offices and resident rooms.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: It was observed inside both facility machinal rooms, extension cords were being used as permanent wiring to power appliance and electrical devices. Cords were fixed to the wall using plastic staples.

5. Hoods, grease-removal devices, fans, ducts and other appurtenances shall be inspected at intervals specified in table 607.3.3.1. Inspections shall be completed by qualified individuals. [Minn. Stat. 144G.45 subd. 2; MSFC 607.3.3.1]

Comments: Kitchens in the facility failed to have proper inspection to maintain compliance with Minnesota fire safety code. Last date of service was February 2023.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: Fire extinguishers were missing their required monthly maintenance inspection checks in accordance with Minnesota State Fire Code 906.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments:

- *Facility's main exterior light was out, creating a hazard for residents to see while traveling to and from the designated smoking area on the other side of the property.*
- *Inside resident rooms 7 and 12 the bathroom exhausted fans failed to operate.*

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The licensee's Fire Safety and Evacuation Plan (FSEP) did not include site-specific employee actions related to the facility's building layout, evacuation routes, or methods for removing residents. The FSEP stated that the alarm system does not alert the fire station; however, during the tour, owner (O)-B reported that they added a stand-alone internet system to the fire panel. The FSEP also indicated that the facility did not have a sprinkler system, even though the building is equipped with one.

2. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Licensee failed to provide documentation that indicated they conducted evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month.