



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

July 27, 2026

Licensee

Amia Assisted Living LLC
7201 Hartkopf Lane
Brooklyn Park, MN 55428

RE: Denial of License Number 419877
Health Facility Identification Number (HFID) 41248
Initial survey; Project Number SL41248015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on July 9, 2026, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

INELIGIBLE LICENSURE TIMELINE

Pursuant to Minn. Stat. § 144G.16, subd. 3 (c), the owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one (1) year following the facility's closure date.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **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>

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Casey DeVries, via email at: Casey.DeVries@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care **no later than July 30, 2026**.

Pursuant to Minn. Stat. § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Casey DeVries, Supervisor, at Casey.DeVries@state.mn.us. Casey DeVries can also be reached by office phone at 651-201-5917.

Sincerely,

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

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41248	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER AMIA ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7201 HARTKOPF LANE BROOKLYN PARK, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL41248015-0 On July 6, 2026, through July 9, 2026, the Minnesota Department of Health conducted an initial survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident who received services under the Provisional Assisted Living Facility license. On July 7, 2026, an immediate order for correction was issued for tag identification 2310. On July 8, 2026, an immediate order for correction was issued for tag identification number 0495.	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.		
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to employ an assisted living director licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 6, 2026, at 9:36 a.m., the surveyor reviewed the BELTSS website and observed no director of record listed for the health facility identification number (HFID) number 41248. On July 6, 2026, at approximately 10:05 a.m., during the entrance conference, owner/clinical nurse supervisor (O/CNS)-C stated they were the assisted living director in training, however, they did not have an assisted living director permit. O/CNS-C stated they passed one of the three exams to become a licensed assisted living	0 110			

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0 110	Continued From page 2 director (LALD). O/CNS-C stated they had a mentor however, the mentor did not work with the licensee. The surveyor inquired who was currently the licensee's assisted living director with a permit or LALD. O/CNS-C stated they were the only one until they could pass their exam. On July 8, 2026, at 6:57 a.m., the surveyor reviewed the BELTSS website and observed O/CNS-C previously held a residency permit, for a different licensee, that expired on August 21, 2024. On July 8, 2026, at approximately 9:32 a.m., during phone interview, O/CNS-C stated they were training to become a LALD and "we have been looking around and it is hard to get people these days." O/CNS-C stated they attempted to take the exam to become a LALD, however, they did not pass one of the exams, so they had to retake the test. During the survey initiated on July 6, 2026, and exited on July 9, 2026, 25 areas of deficient practice were found which included two immediate orders issued related to tag identification numbers 0495 and 2310. The licensee's 4.01 Assisted Living Director policy dated June 15, 2026, indicated the licensee was required to have an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS). In addition, the assisted living director on record was responsible for the licensed assisted living and all operations within the setting. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 110			

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0 110	Continued From page 3	0 110			
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide services in a manner that complied with the Nurse Practice Act sections 148.171 to 148.285. 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: R1's admission assessment dated February 23,	0 450			

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0 450	Continued From page 4 2026, indicated the comprehensive assessment was completed by owner/licensed practical nurse (O/LPN)-A. R1's 14-day assessment dated March 12, 2026, after R1 returned from the hospital, indicated the comprehensive assessment was completed by O/LPN-A. R1's ongoing assessments dated May 14, 2026, May 23, 2026, and June 11, 2026, indicated they were completed by O/LPN-A. R1's ongoing assessments listed above were full comprehensive assessments completed on Residex (a documenting software). R1's admission and 14-day assessments were comprehensive assessments completed via paper format. The assessments indicated O/LPN-A completed every section of the assessment. The assessments all lacked a signature or a co-signature from the RN. On July 8, 2026, at 8:14 a.m., O/LPN-A stated they completed the nursing assessment listed above on the day R1 admitted. O/LPN-A stated owner/clinical nurse supervisor (O/CNS)-C did not come to the facility the day R1 admitted. O/LPN-C stated O/CNS-C came to the facility the following day and reviewed their assessment they completed on R1 and then completed an assessment of their own on R1. O/LPN-A stated when an ongoing 90-day assessment was due they completed the assessment and then let O/CNS-C know the assessment was ready for them to review. LPN-A stated O/CNS-C would come to the facility, review the assessment, and assess the resident. The surveyor asked O/LPN-A to show them O/CNS-C's signature on any assessment. O/LPN-A was unable to produce	0 450			

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0 450	Continued From page 5 any documents for the surveyor and stated, "I did let her know it was completed." On July 8, 2026, at 10:09 a.m., during a phone interview, O/CNS-C stated they complete face-to-face assessments with prospective residents prior to admission. O/CNS-C stated they also conducted an admission assessment, 14-day assessment, and 90-day assessment. O/CNS-C the licensee used to document assessments on paper, however, had transitioned to using Residex. O/CNS-C stated they still used paper documents when they completed their assessments, however, O/LPN-A entered their assessment into Residex since they were still learning how to use the system. O/CNS-C stated Residex training from an outside source cost more money for the company to come in and train on the weekends, so the licensee had O/LPN-A receive the training as they were available during the week. O/CNS-C stated they were still learning how to use Residex from O/LPN-A. The surveyor inquired why another nurse was entering their assessments and signing them as it could be considered falsification of documentation. O/CNS-C stated, "I will talk to her about not putting it into the computer as well." The surveyor asked O/CNS-C to provide any additional assessment documents they had. After completing interview and record review, the surveyor was unable to determine when and if the RN had ever completed a comprehensive assessment on R1. Ostendorf, P.A.P.A.G.P.P.A.S.A.H.W. R. (2025). Fundamentals of Nursing (12th ed.). Elsevier Health Sciences (US). VitalSource Bookshelf Online Section 26. Informatics and	0 450			

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0 450	Continued From page 6 documentation, page 392, Table 26.1, Legal Guidelines for Documentation indicated to never chart for someone else. The Minnesota Statutes 2025 148.171 definitions, Subd. 14. Practice of practical nursing read, the "practice of practical nursing" means the performance, with or without compensation, of those services that incorporates caring for individual patients in all settings through nursing standards recognized by the board at the direction of a registered nurse, advanced practice registered nurse, or other licensed health care provider and includes, but is not limited to: (1) conducting a focused assessment of the health status of an individual patient through the collection and comparison of data to normal findings and the individual patient's current health status, and reporting changes and responses to interventions in an ongoing manner to a registered nurse or the appropriate licensed health care provider for delegated or assigned tasks or activities; (2) participating with other health care providers in the development and modification of a plan of care; (3) determining and implementing appropriate interventions within a nursing plan of care or when delegated or assigned by a registered nurse; (4) implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider; (5) assigning nursing activities or tasks to other licensed practical nurses (LPNs); (6) assigning and monitoring nursing tasks or activities to unlicensed assistive personnel; (7) providing safe and effective nursing care delivery; (8) promoting a safe and therapeutic	0 450			

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0 450	Continued From page 7 environment; (9) advocating for the best interests of individual patients; (10) assisting in the evaluation of responses to interventions; (11) collaborating and communicating with other health care providers; (12) providing health care information to individual patients; (13) providing input into the development of policies and procedures; and (14) accountability for the quality of care delivered, recognizing the limits of knowledge and experience; addressing situations beyond the nurse's competency; and performing to the level of education, knowledge, and skill ordinarily expected of an individual who has completed an approved practical nursing education program described in section 148.211, subdivision 1." The Minnesota Statutes 2025148.171 definitions, Subd. 15. indicated The "practice of professional nursing" means the performance, with or without compensation, of those services that incorporates caring for all patients in all settings through nursing standards recognized by the board and includes, but is not limited to: providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish a health status baseline and plan of care, and address changes in a patient's condition. MN Administrative Rules dated August 11, 2021, 4659.0140 Subp. 2., indicated the nursing assessment or reassessment must be in writing, dated, and signed by the registered nurse who conducted the assessment. In addition, 4659.0140 Subp. 4, indicated a registered nurse shall complete nursing assessments and	0 450			

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0 450	Continued From page 8 reassessments required under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c). Ongoing monitoring may be completed by other licensed nurses acting within the scope of their licenses under Minnesota Statutes, section 148.171. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	0 470			

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0 470	Continued From page 9 (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 daily staff schedule was posted for residents, staff, and visitors to review as required. In addition, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents and staff. 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: On July 6, 2026, at approximately 9:40 a.m., during a facility tour, the surveyor observed no daily staff schedule posted throughout the facility. The surveyor inquired where the posting was located. Owner/licensed practical nurse (O/LPN)-A stated they "printed it out". The surveyor followed O/LPN-A to the basement level of the facility to the laundry room where the surveyor observed O/LPN-A attempting to locate the schedule in multiple binders and folders. O/LPN-A stated they did not have a daily staff	0 470			

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0 470	Continued From page 10 schedule posted in the facility. O/LPN-A stated they printed a schedule and put it in a book however, they normally posted the daily staff schedule on the postings board in the kitchen. O/LPN-A stated the schedule was updated weekly and if there was a change in scheduling it would be updated. On July 7, 2026, at 12:26 p.m., owner/unlicensed personnel (O/ULP)-D stated the licensee did not have a staffing plan. O/LPN-A then provided the surveyor with the employee list and asked if that document was the staffing plan. The surveyor explained to O/LPN-A what a staffing plan was. O/LPN-A stated they had not seen a staffing plan. On July 8, 2026, at 9:32 a.m., via phone interview, owner/clinical nurse supervisor (O/CNS)-C stated O/LPN-A was responsible for the daily staff schedule. The surveyor inquired why the licensee did not have a staffing plan. O/CNS-C stated, "like I said, [O/LPN)-A] takes care of staffing. I don't do staffing." O/CNS-C stated the licensee did not have many staff (there were four staff members, three of which were owners) and they had a group chat to communicate about staffing needs. The licensee's 4.06 Staffing & Scheduling policy dated June 15, 2026, indicated the CNS would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven days a week. In addition, the CNS would develop a 24-hour daily staffing schedule that would identify direct-care staff work shifts, including days and hours worked, and the direct-care staff member resident assignments or work location. The daily work schedule must be posted, after redacting direct-car staff members	0 470			

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0 470	Continued From page 11 resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not	0 480			

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0 480	Continued From page 12 contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 480			

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0 480	Continued From page 13 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 7, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced	0 485			

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0 485	Continued From page 14 by: Based on observation, interview, and record review, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all residents of the facility. 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: On July 6, 2026, at approximately 9:40 a.m., during a facility tour, the surveyor observed multiple menus posted in the kitchen. The menus included four weeks of preplanned meals, and each week included days of the week however, the menus lacked dates the meals would correspond to. On July 7, 2026, at 1:09 p.m., during an interview with owner/unlicensed licensed personnel (O/ULP)-D and owner/licensed practical nurse (O/LPN)-A, O/ULP-D stated it was there mistake they did not put dates on the menu however, R1 refused multiple meals through the day and would only eat breakfast and snacks. O/ULP-D stated if the licensee had multiple residents they would have placed dates on the menus. O/LPN-A stated R1 was a picky eater, and they would show a list of food to R1 and R1 would pick their meals from a list of food items. The licensee's 12.01 Food Service & Menu Planning policy dated June 12, 2026, indicated	0 485			

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0 485	Continued From page 15 menus would be prepared at least one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on February 23, 2026, and began receiving assisted living services. R1 diagnoses included end stage renal disease, anemia, hypertension, protein calorie	0 495			

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0 495	Continued From page 16 malnutrition, and weakness. R1's unsigned service plan dated July 7, 2026, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. R1's prescriber's orders signed February 20, 2026, indicated R1 had a 1500 milliliter (ml) fluid restriction, and had multiple oral medications orders including narcotics. R1's Assessment dated June 11, 2026, indicated the following: - due to dialysis treatments and prescribed fluid restrictions, staff would monitor for signs and symptoms of dehydration, including dry mucous membranes, dizziness, weakness, decreased fluid intake, and change in mental status; - R1 had a history of hypotension (low blood pressure) and was prescribed midodrine; and - R1 experienced intermittent confusion and required monitoring for changes in cognitive status and safety awareness. R1's progress notes dated March 9, 2026, and March 12, 2026, indicated R1 attended dialysis and a nurse from the dialysis clinic reported R1 went unconscious during his dialysis run. When R1 returned home from dialysis his blood pressure was low and R1 looked weak. R1 was transferred to the hospital for evaluation and returned on March 12, 2026. On June 6, 2026, at 10:05 a.m., during the entrance conference with owner/clinical nurse	0 495			

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0 495	Continued From page 17 supervisor (O/CNS)-C, owner/licensed practical nurse (O/LPN)-A, and owner/unlicensed personnel (O/ULP)-D, O/CNS-C stated they had a full time day-shift position at another place of employment as a director of nursing where they completed management tasks such as supervision of staff and assisted with direct patient care. O/CNS-C stated although they did not have their own patient assignment at their other place of employment, they often assisted with transfers and bathing of residents when needed. In addition, O/CNS-C stated they also worked another nursing home care job and attended nursing school. On July 6, 2026, at 10:58 a.m., O/CNS-C stated they needed to leave the facility to attend a medical appointment due to severe back pain. On July 6, 2026, at 12:14 p.m., O/LPN-A stated they needed to leave the facility at 2:00 p.m., to attend clinicals for nursing school and would be unavailable. O/LPN-A stated O/ULP-D could assist the surveyor with paperwork, and O/CNS-C would return later after their medical appointment. On July 6, 2026, at 1:16 p.m., O/LPN-A stated they would be at the facility to assist with the survey all day on July 7, 2026, however they had clinicals for school again on July 8, 2026. On July 7, 2026, at 9:23 a.m., the surveyor called O/CNS-C via phone and left a voicemail to call back as soon as possible. On July 7, 2026, at 9:46 a.m., the surveyor called O/CNS-C again and left a voicemail to contact the surveyor within the next 15 minutes. On July 7, 2026, at 9:53 a.m., O/CNS-C	0 495			

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0 495	Continued From page 18 apologized for not getting back to the surveyor sooner and stated they did not recognize the surveyor's phone number which was why they did not answer the phone. O/CNS-C asked the surveyor if they could provide requested documentation to the surveyor the next day on July 8, 2026, since they could not be at the facility. On July 7, 2026, at 1:18 p.m., the surveyor spoke with O/ULP-D and O/LPN-A and requested that O/CNS-C be present in-person at the facility at an arranged time on July 8, 2026. O/ULP-D stated they relayed the request via text message to O/CNS-C. O/ULP-D and O/LPN-A stated they understood the request and that they would be back at the facility at 7:45-8:00 a.m., the following day. On July 8, 2026, at 8:14 a.m., the surveyor interviewed O/LPN-A and O/ULP-D. O/ULP-D reached out to O/CNS-C via text related to an interview question. O/ULP-D also stated they reached out to O/CNS-C yesterday to tell them they needed to be present at the facility, "but she is not here I don't know." O/ULP-D stated they had not heard back from O/CNS-C. On July 8, 2026, at 8:47 a.m., the surveyor left a voicemail for O/CNS-C and requested a call back within 15 minutes to complete interview questions. On July 8, 2026, at 8:51 a.m., the surveyor received a text message that read, "Morning [surveyor name] I will call you back soon, I'm in meeting". On July 8, 2026, at 9:32 a.m., O/CNS-C stated, "sorry we had back-to-back meetings." The	0 495			

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0 495	Continued From page 19 surveyor continued with interview questions with O/CNS-C. During the middle of the interview, O/CNS-C stated to the surveyor they did not have documentation on hand to review and was unable to provide the surveyor with an answer to the survey question. The surveyor stated that was why they requested O/CNS-C be in person on July 8, 2026, so they could review documents with them. O/CNS-C stated they had back-to-back meetings at their other place of employment. At approximately 10:10 a.m., O/CNS-C abruptly stated they had to go to a meeting that they were already 15 minutes late for. O/CNS-C stated "I have to let you go. The doctor is here. I have to go, it started at 10 a.m." O/CNS-C stated they would contact the surveyor in approximately 30 minutes and hung up the phone. On July 8, 2026, at 10:33 a.m., unlicensed personnel (ULP)-B stated they had not had difficulty getting ahold of O/CNS-C however, they tended to call either O/ULP-D or O/LPN-A if they had a concern. ULP-B stated they felt more comfortable calling the other two and they normally contacted O/LPN-A related to medication questions. On July 8, 2026, as of 11:28 a.m., the surveyor had not received a call back from O/CNS-C. The surveyor called O/LPN-A and left a voicemail pertaining to nurse availability and requested a call back. At 11:30 a.m., the surveyor called O/ULP-D and explained there would be an immediate correction order related to RN availability. O/ULP-D stated they wanted to get in touch with their sister (either O/LPN-A or O/CNS-C) to discuss. At 11:33 a.m., the surveyor received a phone call from O/CNS-C, and the surveyor merged O/ULP-D into the phone call. At	0 495			

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0 495	Continued From page 20 11:34 a.m., O/LPN-A called, and the surveyor merged them into the call as well. O/LPN-A stated she had to step out of her nursing clinical to call the surveyor. The licensee's 6.12 Availability of an RN for Staff policy dated June 12, 2026, indicated the licensee had a RN available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. The RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff was providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	0 580			

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0 580	Continued From page 21 Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. 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: On July 7, 2026, at 1:08 p.m., after multiple requests from the surveyor to see the licensee's quality management plan, owner/licensed practical nurse (O/LPN)-A stated the licensee did not have a quality management plan and the licensee had not conducted a quality management meeting. On July 8, 2026, at 8:23 a.m., O/LPN-A stated they had no previous experience working in an assisted living setting. O/LPN-A stated they did not know what a quality management plan was, and owner/clinical nurse supervisor (O/CNS)-C was training them on assisted living statues and rules. O/LPN-A stated they did not have access to create a quality plan. On July 8, 2026, at approximately 9:32 a.m., via phone interview, the surveyor inquired why the licensee did not have a quality management plan. O/CNS-C stated, "Did you call and ask	0 580			

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0 580	Continued From page 22 [O/LPN-A]? I will have to call cause we are supposed to have one." The licensee's 2.31 Quality Management Project policy dated June 15, 2026, indicated the licensee would have at least one documented quality management project in place at all times and retain records of such projects for at least two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 630 SS=D	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 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 one of one resident (R1).	0 630			

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0 630	Continued From page 23 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 was admitted to the licensee on February 23, 2026, and began receiving assisted living services. R1 diagnoses included end stage renal disease, anemia, hypertension, protein calorie malnutrition, and weakness. R1's unsigned service plan dated July 7, 2026, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. R1's Individual Abuse Prevention Plan dated July 7, 2026, indicated R1 was at risk of being abused by others and included statement of specific measures to be taken to minimize the risk of abuse to R1. R1's IAPP lacked an individualized review or assessment of the R1's risk of abusing other individuals. On July 8, 2026, at 8:23 a.m., the surveyor observed Residex (a documenting software) and observed two questions within the IAPP	0 630			

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0 630	Continued From page 24 assessment, that were not marked in the check box, to indicate if the resident was or was not at risk to abuse others. Owner/licensed practical nurse (O/LPN)-A stated they did not address in the assessment if R1 was or was not at risk to abuse others. O/LPN-A stated R1 was a calm person and was not at risk of abusing others. O/LPN-A stated they knew they had to address the content listed above in the IAPP. On July 8, 2026, at 9:32 a.m., via phone interview, owner/clinical nurse supervisor (O/CNS)-C stated IAPPs addressed if a person was or was not at risk to be abused or was or was not at risk to abuse others. O/CNS-C stated O/LPN-A completed most of R1's paperwork since they were at the facility on a daily basis. O/CNS-C stated most documents were located on Residex however, the licensee did not start using Residex until March or April 2026. O/CNS-C stated the licensee was in the process of uploading paper documents to an electronic version. O/CNS-C stated they "hoped" O/LPN-A did not lose the paper version of the assessment. O/CNS-C stated O/LPN-A was supposed to ensure documents transferred to the new system. The surveyor did not receive a paper version of R1's IAPP prior to the completion of the survey. The licensee's 6.05 Individual Abuse Prevention Plan policy dated June 12, 2026, indicated the IAPP would contain an individualized review or assessment of the person's susceptibility to abuse by another individual including: - other vulnerable adults; - 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.	0 630			

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0 630	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following 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 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 employee records included all required content for three of three employees (unlicensed personnel (ULP)-B,	0 650			

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0 650	Continued From page 26 owner/unlicensed personnel (O/ULP)-D, and owner/licensed practical nurse (O/LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on March 20, 2026, to provide assisted living services to residents. ULP-B's personnel file included Medication Administration- Overview completed April 15, 2026. ULP-B's personnel file included an EduCare (a training software) form titled Medication Administration - Routes dated March 27, 2026. The form included ULP-B's name and a date however; the rest of the form was not completed. The form did not indicate if ULP-B passed or failed each route of medication administration, nor was it signed by ULP-B or a registered nurse (RN). ULP-B's personnel file included an EduCare form titled Medication Administration - Routes dated April 15, 2026. The form included ULP-B's name and a date however; the rest of the form was not completed. The form did not indicate if ULP-B passed or failed each route of medication administration, nor was it signed by ULP-B or a	0 650			

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0 650	Continued From page 27 RN. ULP-B's personnel file lacked the following: - medication training and a medication competency evaluation for unplanned time away from home; and - medication competency evaluation completed by a registered nurse (RN). O/ULP-D O/ULP-D was hired on February 23, 2026, to provide day-to-day operational oversight at the facility and to provide assisted living services to residents. R1's Med Admin Summary - Date Range dated June 2026 indicated O/ULP-D passed oral medication to R1 on June 8, 2026. O/ULP-D's personnel file included a blank EduCare form titled Medication Administration - Routes. The form did not include a name, date, or indicate if O/ULP-D passed or failed each route of medication administration nor was it signed by O/ULP-D or a registered nurse (RN). O/ULP-D's personnel file included a blank EduCare facilitator guide titled Guide to Assisted Living - Minnesota and Assisted Living Bill of Rights -MN. The forms did not include a name of who it belonged to, a date, test completion, or signature from the employee or trainer. O/ULP-D's personnel file lacked the following: - medication training and a medication competency evaluation for unplanned time away from home; - medication competency evaluation completed by a registered nurse (RN); and - orientation which included:	0 650			

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0 650	Continued From page 28 - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - assisted Living Bill of Rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license; and - principles of person-centered planning/service delivery. O/LPN-A O/LPN-A was hired on February 23, 2026, to provide day-to-day operational oversight, supervision to ULP, and to provide assisted living services to residents. On July 7, 2026, at 8:27 a.m., the surveyor observed O/LPN-A take R1's vital signs. At approximately 8:50 a.m., the surveyor observed O/LPN-A administer oral medications to R1. O/LPN-A's personnel file included a blank EduCare facilitator guide titled Guide to Assisted Living - Minnesota and Assisted Living Bill of Rights -MN. The forms did not include a name of who it belonged to, a date, test completion, or signature from the employee or trainer. O/LPN-A's personnel file lacked orientation which included: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency	0 650			

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0 650	Continued From page 29 services; - reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license; and - principles of person-centered planning/service delivery. On July 6, 2026, at 1:58 p.m., ULP-B stated they passed medications to R1. ULP-B stated O/LPN-A trained them on medication administration and time away from home. ULP-B stated both O/LPN-A and owner/clinical nurse supervisor (O/CNS)-C watched them do a return demonstration with medication administration and cleared them to pass medications. On July 7, 2026, at 11:38 a.m., O/ULP-D stated they received training for the topics listed above. O/ULP-D stated O/LPN-A completed their first medication competency evaluation and the second medication competency evaluation was completed by O/CNS-C. On July 7, 2026, at 12:39 p.m., O/LPN-A stated they completed the training for the blank EduCare paperwork located in their employee folder. O/LPN-A stated the licensee did not have a printer, so they were unable to print the EduCare training documents to sign when they completed the training. On July 8, 2026, at 8:14 a.m., O/LPN-A stated O/CNS-C completed a four-hour orientation with them. O/LPN-A stated O/CNS-C reviewed the	0 650			

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0 650	Continued From page 30 expectations for the company, completed training with them to be able to complete quality care and medication administration, and reviewed EduCare (a training software) materials. O/LPN-A stated they received the training on the topics listed above. On July 8, 2026, at 9:32 a.m., during a phone interview, O/CNS-C stated the licensee's orientation process was an in-person training for four hours each day for three or four days. O/CNS-C stated they reviewed the licensee's policies, assisted living statues, reviewed the Minnesota Department of Health (MDH) website, read over the bill of rights, reviewed consumer advocacy services, and had employees complete facility specific trainings. O/CNS-C stated after orientation they had employees sign documents. O/CNS-C stated they started to work with a consultant in June, and they believed the consultant took most of the documents with them. On July 9, 2026, at 8:13 a.m., consultant (C)-E stated they had none of the licensee's documents at their office. C-E stated they worked with the licensee at the facility. The licensee's 4.05 Employee Records policy dated June 15, 2026, indicated employee records would include records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

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0 660	Continued From page 31	0 660			
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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a TB facility risk assessment and a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (owner/licensed practical nurse (O/LPN)-A, owner/unlicensed personnel (O/ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 660			

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0 660	Continued From page 32 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: O/ULP-D O/ULP-D was hired on February 23, 2026, to provide day-to-day operational oversight at the facility and to provide assisted living services to residents. R1's Med Admin Summary - Date Range dated June 2026 indicated O/ULP-D passed oral medication to R1 on June 8, 2026. O/ULP-D's personnel file lacked a health history TB symptom screen and a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. O/LPN-A O/LPN-A was hired on February 23, 2026, to provide day-to-day operational oversight, supervision to ULP, and to provide assisted living services to residents. On July 7, 2026, at 8:27 a.m., the surveyor observed O/LPN-A take R1's vital signs. At approximately 8:50 a.m., the surveyor observed O/LPN-A administer oral medications to R1. O/LPN-A's personnel file included a negative first step TST completed on May 6, 2025. O/LPN-A's personnel file lacked evidence of a first step TST completed within 90 days of hire, a second step TST, and a health history TB symptom screen. On July 6, 2026, at 11:24 a.m., O/LPN-A stated they spoke with owner/clinical nurse supervisor	0 660			

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0 660	Continued From page 33 (O/CNS)-C and O/CNS-C told them they did not complete a TB facility risk assessment however, they screened employees for TB. On July 7, 2026, at 12:39 p.m., during an interview with O/LPN-A and O/ ULP-D, O/LPN-A was able to show the document listed above for their TB screen via computer. O/LPN-A stated they did have another TST that was completed by their school however they were having issues accessing the document. O/ULP-D stated they completed a two-step TST and emailed their information to O/CNS-C. O/ULP-D said their phone was damaged and they were unable to obtain the record. The surveyor did not receive TB testing or a TB health history screen prior to the completion of the survey. On July 8, 2026, at 9:32 a.m., during a phone interview, O/CNS-C stated they forgot to complete a TB facility risk assessment however, they had completed a TB facility risk assessment for their other place of employment (different licensee). O/CNS-C stated O/ULP-D took their TB test at a different place of employment and provided the result to them. O/CNS-C stated they believed O/LPN-A brought in their TB paperwork into the office, however, they did not remember. O/CNS-C stated TB screens were valid for two years if brought in from a different place. The surveyor explained how TB screenings were only valid if completed 90 days prior to hire. The CDC Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 15, 2023, indicated a TB screening included a baseline individual TB risk assessment, TB symptom evaluation, a TB test, and additional evaluation for TB as needed.	0 660			

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0 660	Continued From page 34 The CDC Testing for Tuberculosis: Skin Test dated January 31, 2025, indicated a TB skin test required two skin tests. The Minnesota Department of Health (MDH) Resources and Frequently Asked Questions (FAQs) dated June 5, 2026, indicated each provider licensed by MDH was required to complete a TB risk assessment annually. In addition, TST or interferon-gamma release assays (IGRAs) could be accepted as an acceptable TB screen if it was dated within 90 days of being hired. The licensee's 8.16 Tuberculosis Screening policy dated June 12, 2026, indicated new staff would be screed for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers). In addition, new staff would have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB screening Tool for HCWs. 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;	0 680			

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0 680	Continued From page 35 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP binder titled Emergency Preparedness Survey Binder	0 680			

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0 680	Continued From page 36 Appendix Z last reviewed June 16, 2026, lacked evidence of the following required content: - quarterly missing resident review; - subsistence needs for staff and residents customized to the licensee; - alternative evacuation site and memorandums of understanding with evacuation locations; and - emergency prep. On July 8, 2026, at 8:33 a.m., owner/licensed practical nurse (O/LPN)-A stated they reviewed the EPP however, questions should be directed to owner/clinical nurse supervisor (O/CNS)-C. On July 8, 2026, at approximately 9:32 a.m., via phone interview, the surveyor inquired why the EPP subsistence needs were not customized with the licensee's information. O/CNS-C stated, "I am still working on it." O/CNS-C stated the licensee previously used a different EPP, however, they hired a consultant at the end of June and there were multiple changes that needed to be made in order for EPP be in compliance. O/CNS-C stated the licensee stopped using and destroyed their previous EPP and were now working with the consultant on the new EPP. O/CNS-C stated their primary evacuation sites were a church and a home they owned. The surveyor explained their EPP did not list those places as evacuation sites. The surveyor inquired if the licensee had a memorandum of understanding with the church. O/CNS-C stated they were members of the church. O/CNS-C stated the missing resident policy should be reviewed quarterly however, they did not have documentation of the review. O/CNS-C stated the licensee conducted elopement and fire drills. The surveyor requested to see the documentation. O/CNS-C stated they would have to talk to the consultant as they believed the consultant took the information to the	0 680			

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0 680	Continued From page 37 office. On July 9, 2026, at 8:13 a.m., consultant (C)-E stated they had none of the licensee's documents at their office. C-E stated they worked with the licensee at the facility. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance indicated the licensee had in place an effective and compliant emergency preparedness plan. The intent was the plan would be aligned with the Centers for Medicare and Medicaid services State Operation Manual Appendix Z. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall	0 700			

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0 700	Continued From page 38 establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: On July 6, 2026, at approximately 9:40 a.m., during a facility tour, the surveyor observed R1's medical record along with other staff binders located in the unsecured lower-level laundry room. The surveyor observed that the laundry room did not have a lock on the door leaving R1's medical records accessible to any visitors who entered the facility. On July 6, 2026, at 10:42 a.m., during the entrance conference with owner/clinical nurse supervisor (O/CNS)-C, owner/unlicensed personnel (O/ULP)-D and owner/licensed practical nurse (O/LPN)-A, after the surveyor discussed how the laundry room was not secured, O/LPN-A stated R1's medical record	0 700			

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0 700	Continued From page 39 was normally kept in the locked medication cart. The surveyor asked to see what documents were located in the laundry room and observed R1's admission information, contract, nursing notes, discharge summaries, prescribers orders, and forms from dialysis. In addition, there were multiple binders related to policies and procedures and personnel files on the shelves. O/LPN-A stated they normally didn't keep the resident record in the laundry room but stated they moved them there because they knew the survey was going to take place. The licensee's 2.35 Resident Record - Access & Storage policy dated June 15, 2026, indicated resident records would be kept confidential and locked in a secure area where only authorized staff of the licensee had access. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 775			

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0 775	Continued From page 40 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 July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 800 SS=F	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	0 800			

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0 800	Continued From page 41 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 July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810			

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0 810	Continued From page 42 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 810			

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0 810	Continued From page 43 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
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	01060			

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01060	Continued From page 44 information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident with an emergency relocation (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: R1 was admitted to the licensee on February 23,	01060			

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01060	Continued From page 45 2026, and began receiving assisted living services. R1's diagnoses included end stage renal disease, anemia, hypertension, protein calorie malnutrition, and weakness. R1's unsigned service plan dated July 7, 2026, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. R1's Nursing Note/ Progress Note dated March 9, 2026, indicated R1 was sent to the hospital for an evaluation due to weakness and losing consciousness during dialysis treatment. R1's Nursing Admission Note dated March 12, 2026, indicated R1 returned from the hospital. R1's medical record lacked evidence that the licensee provided R1 an emergency relocation notice. On July 7, 2026, at 12:26 p.m., during an interview with owner/unlicensed personnel (O/ULP)-D and owner/licensed practical nurse (O/LPN)-A, O/ULP-D, and O/LPN-A stated R1 had not received an emergency relocation notice. O/LPN-A stated they did not know what an emergency relocation notice was. On July 8, 2026, at 9:32 a.m., during a phone interview, owner/clinical nurse supervisor (O/CNS)-C described the emergency relocation notice to the surveyor. The surveyor inquired why	01060			

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01060	Continued From page 46 R1 did not receive an emergency relocation notice. O/CNS-C stated, "I can't really tell you why we did not do that." The licensee's 1.23 Emergency Relocation policy dated June 15, 2026, indicated in the event of an emergency relocation, the licensee would provide a written notice that contains, at minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently know; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident had the right to appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff	01440			

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01440	Continued From page 47 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 observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two unlicensed personnel (ULP) (ULP-B, owner/unlicensed personnel (O/ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on March 20, 2026, to provide assisted living services to residents.	01440			

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01440	Continued From page 48 On July 6, 2026, at 1:58 p.m., ULP-B stated they passed medications to R1. ULP-B's personnel file lacked a lacked a 30-day supervision. O/ULP-D O/ULP-D was hired on February 23, 2026, to provide day-to-day operational oversight at the facility and to provide assisted living services to residents. R1' S Med Admin Summary - Date Range dated June 2026 indicated O/ULP-D passed oral medication to R1 on June 8, 2026. O/ULP-D's personnel file lacked a lacked a 30-day supervision. On July 7, 2026, at 1:04 p.m., during an interview with O/ULP-D and owner/licensed practical nurse (O/LPN)-A, O/ULP-D stated they did not receive a 30-day supervision. O/LPN-A stated ULP-B did not receive a 30-day supervision. O/LPN-A stated they have not gotten to performing 30-day supervisions on ULPs. On July 8, 2026, at 9:32 a.m., during a phone interview, owner/clinical nurse supervisor (O/CNS)-C stated the licensee conducted 30-day supervisions with ULPs on the competency evaluations the ULPs completed. CNS-C stated they believed the paperwork for 30-day supervision was misplaced for ULP-B and O/ULP-D. The licensee's 6.17 Supervision of Staff-Delegated Services policy dated July 12, 2026, indicated direct supervision of staff performing	01440			

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01440	Continued From page 49 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee and first performs the delegated tasks for the resident and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed	01530			

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01530	Continued From page 50 the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to provide supervisors of direct-care staff 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 state date and failed to provide direct-care staff 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. This deficient practice applied to two of three employee records reviewed (owner/licensed practical nurse (O/LPN)-A, owner/unlicensed personnel (O/ULP)-D). This practice resulted in a level two violation (a	01530			

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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
01530	Continued From page 51 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee employed four staff to care for R1 24 hours per day, 7 days per week, following R1's admission to the licensee on February 23, 2026. O/ULP-D O/ULP-D was hired on February 23, 2026, to provide day-to-day operational oversight at the facility and to provide assisted living services to residents. R1's Med Admin Summary - Date Range dated June 2026 indicated O/ULP-D passed oral medication to R1 on June 8, 2026. O/LPN-A O/LPN-A was hired on February 23, 2026, to provide day-to-day operational oversight, supervision to ULP, and to provide assisted living services to residents. On July 7, 2026, at 8:27 a.m., the surveyor observed O/LPN-A take R1's vital signs. At approximately 8:50 a.m., the surveyor observed O/LPN-A administer oral medications to R1. O/ULP-D and O/LPN-A's personnel file lacked any hours of dementia or mental health training. On July 7, 2026, at 11:38 a.m., the surveyor	01530			

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01530	Continued From page 52 requested all dementia training and mental health training for O/ULP-D. O/ULP-D provided the surveyor with a book titled Dementia Capable Care Training Participant Workbook. The surveyor inquired how many hours the training was. O/ULP-D stated they did not know how many hours the dementia the book covered. On July 7, 2026, at 12:39 p.m., O/LPN-A stated they completed dementia and mental health training with owner/clinical nurse supervisor (O/CNS)-C however, they did not have a printer, so they were unable to print the sheets to sign that they completed the trainings. The surveyor inquired how many hours of dementia and mental health training they completed with O/CNS-C. O/LPN-A stated they completed two hours of dementia training and two hours of mental health training. On July 8, 2026, at 9:32 a.m., during a phone interview, O/CNS-C stated they provided dementia training in person by completing different types of scenarios that could occur with dementia with the employees. O/CNS-C stated they completed mental health training by watching YouTube videos. O/CNS-C stated the mental health training covered the topics of different mental health diagnoses, and how to de-escalate different situations. O/CNS-C stated they "estimate" they provided about one and a half hours of mental health training and two hours of dementia training. O/CNS-C stated after the training was completed, they had employees sign the training documents. O/CNS-C stated they started to work with a consultant in June, and they believed the consultant took most of the documents with them. On July 9, 2026, at 8:13 a.m., consultant (C)-E	01530			

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01530	Continued From page 53 stated they had none of the licensee's documents at their office. C-E stated they worked with the licensee at the facility. The licensee's 5.03 Dementia Training policy dated June 15, 2026, indicated supervisors of direct care staff would complete eight hours of initial dementia training within 120 hours of the employment start date. In addition, direct care employees would complete eight hours of initial training within 160 hours of the start date. The licensee's 5.10 Training Records policy dated June 15, 2026, indicated documentation of the completed competency evaluation, training, retraining, or orientation would be provided to the employee at the time of the evaluation or when training was completed. The licensee's policies did not address the mental health training requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01610			

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01610	Continued From page 54 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an initial nursing assessment completed by a registered nurse (RN) of the physical and cognitive needs for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 23, 2026, and began receiving assisted living services. R1's diagnoses included end stage renal disease, anemia, hypertension, protein calorie malnutrition, and weakness. R1's unsigned Addendum to Contract - Waiver-MN dated June 25, 2026, indicated R1 received	01610			

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01610	Continued From page 55 assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. In addition, the service plan indicated the licensee shall conduct a nursing assessment by a registered nurse (RN) 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 moves in, whichever is earlier. R1's admission assessment was completed on February 23, 2026, by owner/licensed practical nurse (O/LPN)-A. O/LPN-A completed all sections of the assessment. On July 8, 2026, at 8:14 a.m., O/ LPN-A stated they completed the nursing assessment listed above on the day R1 admitted. O/LPN-A stated owner/clinical nurse supervisor (O/CNS)-C did not come to the facility the day R1 admitted. O/LPN-C stated O/CNS-C came to the facility the following day and reviewed their assessment they completed on R1 and then completed an assessment of their own on R1. On July 8, 2026, at 10:09 a.m., during a phone interview, O/CNS-C stated they complete face-to-face assessments with prospective residents prior to admission. O/CNS-C stated they also conducted an admission assessment, 14-day assessment, and 90-day assessment. O/CNS-C the licensee used to document assessments on paper, however, had transitioned to using Residex. O/CNS-C stated they still used paper documents when they completed their assessments, however, O/LPN-A entered their	01610			

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01610	Continued From page 56 assessment into Residex since they were still learning how to use the system. O/CNS-C stated Residex training from an outside source cost more money for the company to come in and train on the weekends, so the licensee had O/LPN-A receive the training as they were available during the week. O/CNS-C stated they were still learning how to use Residex from O/LPN-A. The surveyor inquired why another nurse was entering their assessments and signing them as it could be considered falsification of documentation. O/CNS-C stated, "I will talk to her about not putting it into the computer as well." The surveyor asked O/CNS-C to provide any additional assessment documents they had. Although O/LPN-A completed R1's initial assessment, the assessment was not completed by the RN as stated in R1's service plan. R1's initial assessments showed evidence that all sections of the assessment were completed by a licensed practical nurse (LPN) and lacked a signature or co-signature from the RN. Further, the RN did not come to the facility to assess R1 until the day after admission per interview. In addition, the licensee did not follow their own policy related to resident assessments. The licensee was unable to produce an assessment that indicated R1's initial assessment was conducted by a RN or reviewed and co-signed by an RN prior to the completion of the survey. After completing interview and record review, the surveyor was unable to determine when and if the RN had ever completed a comprehensive assessment on R1.	01610			

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01610	Continued From page 57 Ostendorf, P.A.P.A.G.P.P.A.S.A.H.W. R. (2025). Fundamentals of Nursing (12th ed.). Elsevier Health Sciences (US). VitalSource Bookshelf Online Section 26. Informatics and documentation, page 392, Table 26.1, Legal Guidelines for Documentation indicated to never chart for someone else. The licensee's 6.02 Assessment Schedules policy dated June 12, 2026, indicated the following: - the RN was responsible for the initial resident nursing assessment; - initial medication management assessment was to be conducted by the RN; and - individual abuse prevention plans were to be conducted by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective 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	01620			

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01620	Continued From page 58 circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to conduct ongoing nursing	01620			

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01620	Continued From page 59 assessments completed by a registered nurse (RN) of the physical and cognitive needs for one of one resident. (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 23, 2026, and began receiving assisted living services. R1's diagnoses included end stage renal disease, anemia, hypertension, protein calorie malnutrition, and weakness. R1's unsigned Addendum to Contract - Waiver-MN dated June 25, 2026, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. In addition, the service plan indicated the following: - monitoring and focused assessments may be conducted by a licensed practical nurse; - resident reassessment and monitoring will be conducted by the RN no more than 14 calendar days after initiation of services; and - ongoing resident reassessment and monitoring	01620			

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01620	Continued From page 60 must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of assessment. R1's 14-day assessment was completed on March 12, 2026, after R1 returned from the hospital. All sections of the assessment were completed by owner/licensed practical nurse (O/LPN)-A. R1's ongoing assessments completed on May 14, 2026, May 23, 2026, and June 11, 2026, indicated all sections were completed by O/LPN-A. On July 8, 2026, at 8:14 a.m., O/LPN-A stated when an ongoing 90-day assessment was due they completed the assessment and then let O/CNS-C know the assessment was ready for them to review. LPN-A stated O/CNS-C would come to the facility, review the assessment, and assess the resident. The surveyor asked O/LPN-A to show them O/CNS-C's signature on any assessment. O/LPN-A was unable to produce any documents for the surveyor and stated, "I did let her know it was completed." On July 8, 2026, at 10:09 a.m., during a phone interview, O/CNS-C stated they complete face-to-face assessments with prospective residents prior to admission. O/CNS-C stated they also conducted an admission assessment, 14-day assessment, and 90-day assessment. O/CNS-C the licensee used to document assessments on paper, however, had transitioned to using Residex. O/CNS-C stated they still used paper documents when they completed their assessments, however, O/LPN-A entered their assessment into Residex since they were still	01620			

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01620	Continued From page 61 learning how to use the system. O/CNS-C stated Residex training from an outside source cost more money for the company to come in and train on the weekends, so the licensee had O/LPN-A receive the training as they were available during the week. O/CNS-C stated they were still learning how to use Residex from O/LPN-A. The surveyor inquired why another nurse was entering their assessments and signing them as it could be considered falsification of documentation. O/CNS-C stated, "I will talk to her about not putting it into the computer as well." The surveyor asked O/CNS-C to provide any additional assessment documents they had. Although O/LPN-A completed R1's assessments timely, the assessments were not completed by the RN as indicated in R1's service plan. All of R1's assessments showed evidence that they were completed by a licensed practical nurse (LPN) and lacked a signature or co-signature from an RN. In addition, the licensee did not follow their own policy related to resident assessments. The licensee was unable to produce an assessment that indicated any of R1's assessments were conducted by an RN or reviewed and co-signed by an RN prior to the completion of the survey. After completing interview and record review, the surveyor was unable to determine when and if the RN had ever completed a comprehensive assessment on R1. Ostendorf, P.A.P.A.G.P.P.A.S.A.H.W. R. (2025). Fundamentals of Nursing (12th ed.). Elsevier Health Sciences (US). VitalSource Bookshelf	01620			

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01620	Continued From page 62 Online Section 26. Informatics and documentation, page 392, Table 26.1, Legal Guidelines for Documentation indicated to never chart for someone else. The licensee's 6.02 Assessment Schedules policy dated June 12, 2026, indicated the following: - the resident reassessment and monitoring was to be conducted no more than 14 days after the initiation of services and was to be conducted by a RN; - ongoing resident and reassessment and monitoring needed to be conducted as needed based on changes of the resident but could not exceed 90 days from the previous assessment and must be conducted by a RN; - changes in resident condition was to be conducted as needed by a RN; - weekend and holiday assessments where to be completed by the RN; - ongoing medication management reassessment was to be conducted by the RN; and - individual abuse prevention plans were to be conducted by the RN. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the	01640			

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01640	Continued From page 63 facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to finalize a current written service plan that included a signature or other authentication by the facility and by the resident documenting an agreement on the services to be provided for one of one resident (R1). In addition, the licensee failed to implement the service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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:	01640			

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01640	Continued From page 64 R1 was admitted to the licensee on February 23, 2026, and began receiving assisted living services. R1's diagnoses included end stage renal disease, anemia, hypertension, protein calorie malnutrition, and weakness. On July 7, 2026, at approximately 8:50 a.m., the surveyor observed owner/licensed practical nurse (O/LPN)-A administer oral medications to R1. R1's admission assessment was completed on February 23, 2026, by O/LPN-A. R1's 14-day assessment was completed oMarch 12, 2026, after R1 returned from the hospital. The assessment was completed by O/LPN-A. R1's ongoing assessments completed May 14, 2026, May 23, 2026, and June 11, 2026, were all completed by O/ LPN-A. R1's unsigned Addendum to Contract - Waiver-MN dated June 25, 2026, completed in Residex (a documentation software), indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. In addition, the service plan indicated the following: - the licensee shall conduct a nursing assessment by a registered nurse (RN) 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	01640			

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01640	Continued From page 65 moves in, whichever is earlier; - monitoring and focused assessments may be conducted by a licensed practical nurse; - resident reassessment and monitoring will be conducted by the RN no more than 14 calendar days after initiation of services; and - ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of assessment. R1's service plan lacked a signature or other authentication by the facility and by the resident documenting an agreement on the services to be provided. In addition, the licensee's RN did not complete the assessments listed above as directed and written in R1's service plan. On July 7, 2026, at 10:05 a.m., O/LPN-A stated they were using the department of human services (DHS) Support Plan as R1's service plan. O/LPN-A stated they were unable to locate the support plan but it contained services the licensee was to provide to R1 and included services the licensee would be reimbursed for. The surveyor did not receive the DHS support plan prior to the conclusion of the survey. On July 7, 2026, at 10:28 a.m., O/LPN-A provided the surveyor with a signed contract and an unsigned service plan from the Residex system. O/LPN-A stated they provided R1 with the DHS support plan as R1's service plan and a signed contract provided by the licensee when R1 admitted. O/LPN-A stated they did not have a service plan that was completed in Residex signed by R1. On July 8, 2026, at 8:14 a.m., O/LPN-A stated	01640			

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01640	Continued From page 66 they completed the nursing assessment listed above on the day R1 admitted. O/LPN-A stated owner/clinical nurse supervisor (O/CNS)-C did not come to the facility the day R1 admitted. O/LPN-C stated O/CNS-C came to the facility the following day and reviewed their assessment they completed on R1 and then completed an assessment of their own on R1. O/LPN-A stated when an ongoing 90-day assessment was due they completed the assessment and then let O/CNS-C know the assessment was ready for them to review. LPN-A stated O/CNS-C would come to the facility, review the assessment, and assess the resident. The surveyor asked O/LPN-A to show them O/CNS-C's signature on any assessment. O/LPN-A was unable to produce any documents for the surveyor and stated, "I did let her know it was completed." On July 8, 2026, at 10:09 a.m., during a phone interview, O/CNS-C stated they complete face-to-face assessments with prospective residents prior to admission. O/CNS-C stated they also conducted an admission assessment, 14-day assessment, and 90-day assessment. O/CNS-C the licensee used to document assessments on paper, however, had transitioned to using Residex. O/CNS-C stated they still used paper documents when they completed their assessments, however, O/LPN-A entered their assessment into Residex since they were still learning how to use the system. O/CNS-C stated Residex training from an outside source cost more money for the company to come in and train on the weekends, so the licensee had O/LPN-A receive the training as they were available during the week. O/CNS-C stated they were still learning how to use Residex from O/LPN-A. The surveyor inquired why another nurse was entering their assessments and	01640			

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01640	Continued From page 67 signing them as it could be considered falsification of documentation. O/CNS-C stated, "I will talk to her about not putting it into the computer as well." The surveyor asked O/CNS-C to provide any additional assessment documents they had. The assessments were not completed by the RN as stated in the R1's service plan. All of R1's assessments showed evidence that they were completed by a licensed practical nurse (LPN) and lacked a signature or co-signature from an RN. On July 8, 2026, at 11:38 a.m., via phone interview, O/CNS-C inquired what a service plan was. The surveyor explained what a service plan was. O/CNS-C began to explain services R1 received. The surveyor intervened and asked specifically what document they used for their service plan. O/CNS-C stated when R1 admitted they provided R1 with a menu, bill of rights, and had a preadmission assessment of the resident's needs. O/CNS-C stated they followed prescriber's orders and created an individualized plan for R1. O/CNS-C directed the surveyor to ask O/LPN-A for the document. The licensee's 6.08 Service Plan policy dated June 12, 2026, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of	01690			

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01690	Continued From page 69 medication according to their policy and State and Federal regulations for disposition of medication. 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: On July 6, 2026, at 12:25 p.m., the surveyor observed owner/licensed practical nurse (O/LPN)-A complete a medication set-up for one week of R1's medications. O/LPN-A dropped two medications during the medication set-up, calcitriol 0.25 micrograms (mcg) and midodrine hydrochloride (HCL) 10 milligrams (mg). After the medication set-up was completed the surveyor observed O/LPN-A place the dropped calcitriol and midodrine into the garbage can located in the facility's kitchen. O/LPN-A stated they disposed of dropped medications then let the pharmacy know. O/LPN-A stated they were supposed to put the medication in a special container, however, the facility did not have one so they placed the medications in the garbage can. The surveyor inquired if they were going to document the disposal. O/LPN then called owner/unlicensed personnel (O/ULP)-B over and documented in Residex (a documenting software) that they disposed of the two medications listed above in a hazardous waste container. On July 8, 2026, at 8:14 a.m., O/LPN-A stated they normally flushed medication down the toilet	01690			

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01690	Continued From page 70 with a second witness when they disposed of medications. The surveyor inquired why they documented that they put the medication into a hazardous waste container when they did not. O/LPN-A stated they did not have a container, but they did not want the medication to be laying on the floor, so they threw it away and documented with the options they had in the software system. On July 8, 2026, at 11:38 a.m., during a phone interview, owner/clinical nurse supervisor (O/CNS)-C stated most of the time the licensee sent medications back to the pharmacy for disposal. The surveyor inquired how they were supposed to dispose of a dropped medication. O/CNS-C then stated O/LPN-A controlled how medications were destroyed at the facility and to ask them. The licensee's 7.23 Medication Disposal policy dated June 12, 2026, indicated employees of the licensee would dispose of any medication, as needed, in a proper way including following the guidelines of the Minnesota Board of Pharmacy. The Minnesota Board of Pharmacy website linked to Minnesota Pollution Control Agency (MN PCA) article dated March 7, 2027, titled Don't Flush Medications Down the Drain, and indicated not to throw prescriptions or medication down the toilet or drain and not to put them in the trash. MN PCA recommended using a collection site to destroy medication or had recommendations of how to dispose of medication if a collection site was not available. The MN PCA article titled Changes in Pharmaceutical Waste Management dated November 2020 indicated residential care facilities with a capacity of six residents or less	01690			

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01690	Continued From page 71 may consider their waste to be exempt household waste. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for 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	01730			

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01730	Continued From page 72 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication plan to include documentation of specific resident instructions related to the administration of medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 23, 2026, and began receiving assisted living services.	01730			

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01730	Continued From page 73 R1's diagnoses included end stage renal disease, anemia, hypertension, protein calorie malnutrition, and weakness. R1's unsigned service plan completed in Residex (a documentation software) dated July 7, 2026, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. On July 6, 2026, at 12:25 p.m., the surveyor observed owner/licensed practical nurse (O/LPN)-A complete a medication set up for R1. The surveyor observed O/LPN-A place two tablets of 1,000 units (u) of Vitamin D into the Medi planner for each day Monday through Sunday. On July 7, 2026, at 8:27 a.m., the surveyor observed O/LPN-A compare a bottle of vitamin D to the medication administration record (MAR) for R1. O/LPN-A stated the medication bottle was for vitamin D 1000 u so R1 would need two tablets. O/LPN-A then looked into the Medi planner and counted to two tablets of vitamin D. O/LPN-A continued to verify medications in the Medi planner and then administered oral medications to R1 at approximately 8:50 a.m. R1's Med Admin Summary - Date Range printed July 7, 2026, included vitamin D take one tablet 2000 units (u) by mouth once daily at 8:30 a.m. The MAR also indicated unlicensed personnel (ULP) and licensed personnel passed medication to R1. The MAR instructions for vitamin D	01730			

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01730	Continued From page 74 administration did not match how the staff would administer vitamin D to R1 as the MAR indicated one tablet of vitamin D was required for R1 vs two tablets. This has the potential to cause a medication administration error during the medication verification process with the Medi planner. On July 8, 2026, at approximately 8:14 a.m., O/LPN-A stated R1's insurance would not cover the 2000 u tablet of vitamin D, so they bought an over the counter (OTC) 1,000 u tablet of vitamin D. O/LPN-A stated they should have edited the order to show R1 needed two tablets of 1000 u verses one tablet of 2000 u of vitamin D. The licensee's 7.03 Medication Management Individualized Plan policy dated July 12, 2026, the licensee would develop and maintain a current individualized medication management record for each resident based on the resident assessment. The plan would include documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days		01730		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced		01820		

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01820	Continued From page 75 by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on February 23, 2026, and began receiving assisted living services. R1's diagnoses included end stage renal disease, anemia, hypertension, protein calorie malnutrition, and weakness. R1's unsigned service plan dated July 7, 2026, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. R1's Med Admin Summary - Date Range printed July 7, 2026, included oxycodone 5 milligrams (mg) every four hours as needed for pain. R1's After Visit Summary (AVS) dated May 12,	01820			

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01820	Continued From page 76 2026, included oxycodone 5 mg by mouth every four hours as needed for pain. The AVS lacked a prescriber's signature. On July 8, 2026, at 8:14 a.m., owner/licensed practical nurse (O/LPN)-A stated R1 came back from a medical appointment with the AVS listed above and the prescription for oxycodone went to the pharmacy. O/LPN-A stated they called the prescriber's office after the appointment, and the registered nurse (RN) told them the prescriber sent the order to the pharmacy and that was why the AVS was not signed. O/LN-A stated they did not have documentation related to the oxycodone conversation with prescriber's RN. The licensee's 7.17 Medication & Treatment Orders - Receiving policy dated June 12, 2026, indicated all orders for medication and treatments must be dated and signed by the prescriber and must be current and consistent with the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
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:	02310			

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02310	Continued From page 77 Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) who utilized 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 7, 2026, at 8:27 a.m., the surveyor entered R1's room and observed bilateral upper quarter hospital bed rails model number 6640P, securely attached to a hospital style bed frame. R1 was admitted to the licensee on February 23, 2026, and began receiving assisted living services. R1 diagnoses included end stage renal disease, anemia, hypertension, protein calorie malnutrition, and weakness. R1's unsigned service plan dated July 7, 2026, indicated R1 received assistance with activities, ambulation, appointments, transportation, bathing, dressing, behavior management, grooming, hearing aids, housekeeping, laundry, meals, medication administration, nail care, vital sign monitoring, socialization, wheelchair mobility, and safety checks. R1's record included a risk and benefit discussion	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41248	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER AMIA ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7201 HARTKOPF LANE BROOKLYN PARK, MN 55428		
(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
02310	Continued From page 78 completed on February 23, 2026. R1's Bed Safety Assessment dated June 11, 2026, indicated the following: - R1 had an electric bed; - R1's mattress was original to bed; - R1 had no assistive device needs for bed; - R1 bed safety assessment completed. "Bed rails are in use and all bed safety zones were evaluated. Measurements are within FDA [Food and Drug Administration]-recommended guidelines. No entrapment hazards identified at this time." - R1's bed rail assessment was completed by owner/licensed practical nurse (O/LPN)-A, not a registered nurse (RN) as required by the licensee's policy. R1's medical record lacked the following required documentation: - type of bed rail in use; - an assessment of the individual's cognitive and physical status as they pertain to the bed rail to determine the purpose and intention of the bed rail; - measurements of zones of entrapment; - the resident's bed rail use/need assessment; - the resident's preferences; - physical inspection of bed rail and mattress to check for stability and correct installation; and - an assessment completed by an RN (as required by the licensee's policy). On July 7, 2026, at 8:54 a.m., the surveyor requested any documents related to bed rails. On July 7, 2026, at 9:03 a.m., O/LPN-A stated they mismarked R1's assessment that stated R1 had no assistive device needs for bed. O/LPN-A stated R1 used bed rails for positioning. O/LPN-A	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41248	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER AMIA ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7201 HARTKOPF LANE BROOKLYN PARK, MN 55428		
(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
02310	Continued From page 79 stated R1 did not have a bed rail upon admission, however, when they completed the admission assessment they noticed R1 would benefit from a bed rail to increase independence. O/LPN-A stated they exchanged beds on day of admission so R1 would have bed rails. O/LPN-A stated they knew bed rails were safe if they were secured and not shaky. The surveyor inquired what O/LPN-A meant by all bed zones were evaluated. O/LPN-A stated all four corners of the bed were evaluated and how R1 was able to position themselves to get in and out of bed. O/LPN-A stated they did not know if bed rail measurements were taken and the surveyor would need to speak with owner/clinical nurse supervisor (O/CNS)-C. The surveyor inquired if they knew what the FDA zones 1-4 were. O/LPN-A stated no they did not, so, the surveyor then reviewed the FDA website with O/LPN-A. O/LPN-A stated they assessed R1's cognition and physical ability as it pertained to bed rails however, they did not have documentation of the assessment. The surveyor asked again if they had any further assessment. O/LPN-A stated no. On July 7, 2026, at 9:53 a.m., via phone interview, O/CNS-C stated when R1 came to the facility he needed bed rails to assist with shifting his weight in bed. O/CNS-C stated they provided risks and benefits to R1. O/CNS-C stated bed rails were not a restraint to R1. O/CNS-C stated O/LPN-A and themselves completed bed rail assessments and they were completed every 90 days. O/CNS-C stated bed rail assessments used to be completed by paper until March or April when the licensee changed to using Residex (a documenting software) for all further bed rail assessments. The surveyor requested paper bed rail assessment as they did not receive one from O/LPN-A after requested. O/CNS-C stated they	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41248	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER AMIA ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7201 HARTKOPF LANE BROOKLYN PARK, MN 55428		
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02310	Continued From page 80 would call O/LPN-A to provide it to the surveyor. The surveyor inquired if the licensee measured bed rail zones of entrapment. O/CNS-C stated, "I don't remember zones". O/CNS-C stated they did not have the chart in front of them, so they did not know if any measurements were taken. O/CNS-C asked the surveyor if they would be back tomorrow so if they found the document they could provide it then. As of July 7, 2026, at 10:50 a.m., the surveyor had not received further documentation related to bed rails for R1. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated April 17, 2026, 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. Additionally, the licensee must ensure the med rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also, it included, "Best practice for documentation about a resident's bed rails include but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41248	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER AMIA ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7201 HARTKOPF LANE BROOKLYN PARK, MN 55428		
(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	
02310	Continued From page 81 each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's 6.28 Side Rails policy dated June 12, 2026, indicated when side rails were in use an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The licensee's staff will determine if the side rails was considered to be safe defined as meeting all of the requirements listed below: - the side rail was used consistent with the manufacturer's directions. Beware of side rails that slide between the mattress and box spring designed for toddler use; - the side rails were installed securely and maintained in good operating condition. Be aware of "wobbly" side rails; and - the side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rails zone 1, 2, and 3 must not exceed 4.75. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Amia Assisted Living llc
7201 Hartkof Lane
Brook Park, mn 55428
Hennepin County
Parcel:

Phone:
JARBAHEVELYN@GMAIL.COM

License Info

License: HFID 41248

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8044261195
Inspection Type: Full - Single
Date: 7/7/2026 Time: 10:06:23 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3 CFP#: 2*

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

COMMENT: Certificate lapsed in January, 2026.

Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 3-400A Destroying Organisms: cooking time/temperature, freezing

3-401.11D(1) & (2) *Priority Level: Priority 3 CFP#: 18*

MN Rule 4626.0340D(1)(2) Discontinue offering raw or undercooked fish, shellstock, eggs, steak tartar or comminuted beef to a highly susceptible population which includes children.

COMMENT: Raw shell eggs prepared undercooked are not pasteurized.

Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: No waterproof irreversible thermometer or stickers/strips for dishwasher.

Comply By: 7/7/2026 Originally Issued On: 7/7/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

COMMENT: Mouse droppings in cupboard below sink next to trap in kitchen.

Comply By: 7/7/2026 Originally Issued On: 7/7/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Ashley Crews. Inspection report reviewed on site with Evelyn.

Kitchen consists of vinyl floors, painted gypsum walls and ceiling, wooden hollow-base cabinets, granite counters, and domestic kitchen.

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.

Report Number: F8044261195

Inspection Type: Full

Date: 7/7/2026

Page: 2

I acknowledge receipt of the Rochester District Office inspection report number F8044261195 from 7/7/2026

Evelyn
Owner



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



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
Amia Assisted Living Ilc	Report Number: F8044261195
Brook Park	Inspection Type: Full
County/Group: Hennepin County	Date: 7/7/2026
	Time: 10:06:23 AM

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

Location: Refrigerator at 38.5 Degrees F.

Comment:

Violation Issued?: No

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

Location: Refrigerator at 38.0 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Establishment Info	Inspection Info
Amia Assisted Living Ilc	Report Number: F8044261195
Brook Park	Inspection Type: Full
County/Group: Hennepin County	Date: 7/7/2026
	Time: 10:06:23 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dishwasher
Location: Kitchen **Equal To** 160.0 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41248015-0	Date: 7/7/2026
Facility Name: AMIA ASSISTED LIVING LLC	
Facility Address: 7201 Hartkopf Lane Brooklyn park 55428	

☒ **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. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

Comments: Inside the laundry room of the facility the exhaust vent for the dryer was completely detached from the unit allowing exhaust and lint from the dryer to fill the room.

3. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: No carbon monoxide detectors were located anywhere inside the facility. Building utilized gas burning water heater and furnace.

4. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

Comments: The smoke alarm devices provided throughout the facility did not display any indication that they were listed to underwriter laboratories (UL) standards to comply with requirements.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; 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:

- *The basement bathroom shower area was experiencing a water issue. The sheetrock around the shower was waterlogged, which was evidence of an active water leak.*
- *Inside facility laundry room there were insulation and wires exposed.*
- *There was water damage on the ceiling tiles in the basement.*

☒ **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 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. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of residents that need assistance or any resident-specific procedures to staff for assisting residents during an evacuation.

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. No documentation of training records was provided.