DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

October 13, 2026

Licensee
Silver Meadows Assisted Living
813 Meyer Street North
Maplewood, MN 55119

RE: Denial of License Number 420759
Health Facility Identification Number (HFID) 41263
Initial survey; Project Number(s) SL41263001

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on September 11, 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(s), 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.

INELIGIBILE 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. § 144G55. 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, RENEE ANDERSON, via email at: Renee.L.Anderson@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 **10/16/2026**.

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 Renee L. Anderson, Supervisor, at Renee.L.Anderson@state.mn.us. Renee L. Anderson can also be reached by office phone at 651-201-5871.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41263	A. BUILDING: _____ B. WING _____	09/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

(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: SL41263001-0 On September 8, 2026, through September 11, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Provisional Assisted Living Facility license. An immediate order was identified on September 10, 2026, issued for SL41263001-0, tag identification 0470. The licensee took appropriate action to address the immediate risk to the residents.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules. 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 the potential to affect a large portion or all of the residents). The findings include: During the initiation of this survey on September 8, 2026, at 10:08 a.m., licensed assisted living	0 250		

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0 250	Continued From page 3 director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication and treatment management services, and they were familiar with the assisted living regulations. The licensee's Provisional Assisted Living Licensure Information and Application signed on March 27, 2026, section titled Official Verification of Owner or Authorized Agent, (page 17 of the application), identified, "I certify I have read and understand the following [a filled black square box indicated agreement with each of the following]: -https://www.revisor.mn.gov/statutes/cite/144G; -https://www.revisor.mn.gov/rules/4659/; -https://www.revisor.mn.gov/statutes/cite/626.557; -https://www.revisor.mn.gov/statutes/cite/144.6502; -I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data(https://www.revisor.mn.gov/statutes/cite/13.04), the commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen,	0 250		

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0 250	Continued From page 4 health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices; -I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (https://www.revisor.mn.gov/statutes/cite/144.051), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license; -I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (https:// www.revisor.mn.gov/statutes/cite/144G), and Minnesota Rules, chapter 4659 (https://www.revisor.mn.gov/rules/4659/), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract; -I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and belief, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required; and -I attest to have all required policies and procedures of Minn. Stat. chapter 144G (https://www.revisor.mn.gov/statutes/cite/144G) and Minn. Rules chapter 4659(https://www.revisor.mn.gov/rules/4659/), in place upon licensure and to keep them current as applicable."	0 250		

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0 250	Continued From page 5 Page 18 was electronically signed by LALD/CNS-A on March 27, 2024. A Provisional Assisted Living License was granted to licensee effective April 28, 2025, with an expiration date of April 27, 2026. As a result of this survey, the following orders were issued: 0470, 0480, 0550, 0580, 0630, 0660, 0680, 0730, 0790, 0800, 0810, 1370, 1380, 1420, 1470, 1530, 1730, 1820, 1880, 1890,1940, 1970, and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
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,	0 470		

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0 470	Continued From page 6 who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to always ensure sufficient staffing to meet the reasonably foreseeable unscheduled needs of each resident as required. In addition, the licensee failed to ensure the daily staff schedule included awake, overnight 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 8, 2026, at 10:55 a.m., the surveyor observed and reviewed the licensee's posted "Monthly Calendar Employee Schedule" (daily staff schedule), dated August 23 to October 3, 2026. The owner/unlicensed	0 470	The licensee took appropriate action to address the immediate risk to the residents.	

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0 470	Continued From page 7 personnel(O/ULP)-D was scheduled to work the overnight shifts on all dates except August 28, September 4, September 18, September 25, and October 2, 2026. Review of the licensee's Employee List updated during the survey by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on September 8, 2026, indicated eight employees were listed to cover 24/7 hours at the facility. O/ULP-D was listed as one of the eight employees. R1 R1 was admitted on April 7, 2026, and had diagnoses including cerebral vascular accident (CVA) (a stroke), carotid artery stenosis (narrowing of the blood vessel), and type two diabetes. R1's Individualized Service Plan dated June 12, 2026, indicated R1 received services including assistance with housekeeping, meals, laundry, activities of daily living (ADLs), activities, day program, overnight support, blood pressure monitoring, blood glucose monitoring, and medication administration. R2 R2 was admitted on July 1, 2026, and had diagnoses including chronic gout of bilateral hands and feet, history of stroke, and hypertension. R2's Individualized Service Plan dated July 1, 2026, indicated R2 received assistance with services including housekeeping, meals, laundry, ADLs, transfers and walking for fall precautions, activities, day program, blood pressure monitoring, and medication administration.	0 470		

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0 470	Continued From page 8 On September 8, 2026, at 1:20 p.m., during the engineer surveyor's tour with LALD/CNS-A, the engineer observed another bedroom in the front of the house. The surveyor observed the room contained a bed with bedding and items such as clothing, shoes, and other miscellaneous personal items. On September 8, 2026, at 1:56 p.m., when asked by the surveyor what the front bedroom was used for, LALD/CNS-A stated, no one sleeps in there and the bed has always been there. LALD/CNS-A verbalized the staff were using that room to have some private space for changing clothes, for breaks, and training purposes. On September 9, 2026, at 5:00 a.m., the surveyor arrived at the facility and pressed the audible Ring doorbell. The surveyor observed a couple small lights on inside the home, a car in the driveway, and no outside lights on. -at 5:05 a.m., nobody had answered the door after five minutes, so the surveyor knocked on the front door of the home. -at 5:06 a.m., O/ULP-D answered the door. O/ULP-D's eyes appeared puffy and he acted surprised to see the surveyors at that hour. -at 5:22 a.m., the surveyor observed the front staff bedroom. The bed sheets and blanket were unmade and appeared to have been used. On September 9, 2026, at 6:28 a.m., the surveyor asked O/ULP-D if the front staff bedroom was a sleep room at night and he stated, "yes, it's kind of like a breakroom." On September 9, 2026, at 7:07 a.m., the surveyor asked O/ULP-D if we woke him up this morning arriving early and O/ULP-D stated, "no, maybe	0 470		

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0 470	Continued From page 9 like a 45-minute nap." On September 9, 2026, at 8:00 a.m., the surveyor observed the front staff bedroom, and the bed was now made. On September 10, 2026, at approximately 8:30 a.m., the engineer surveyor stated, via phone, he asked LALD/CNS-A some questions about the use of the bedroom and LALD/CNS-A verbalized, she sometimes would stay there and not stop home, so she had stored some clothing and personal items there. The licensee's STAFFING, DIRECT-CARE STAFFING PLAN & DAILY SCHEDULE policy, effective April 28, 2025, indicated, "2. Staffing: a. From the hours of 10:00pm to 6:00am, direct-care staff will respond to a resident request for assistance with health or safety needs within a reasonable amount of time. b. A minimum of two direct-care staff will be scheduled and available to assist at all times whenever a resident requires the assistance of two. c. One or more persons will be available 24-hours per day, seven days per week who are responsible for responding to the requests of residents for assistance for health and safety needs. Persons will be: i. Awake ii. Located in: 1. The same building -OR- 2. An attached building -OR- 3. On a contiguous campus within the facility in order to respond within a reasonable amount of time iii. Capable of communicating with residents iv. Capable of summoning appropriate assistance	0 470		

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0 470	Continued From page 10 v. Capable of following directions d. A Registered Nurse will be available to staff working at all times. Availability may be in person, via phone, or via other electronic communication method." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate STAFFING PLAN REVIEW The licensee lacked a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured that the facility could respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On September 8, 2026, at 1:05 p.m., LALD/CNS-A stated she was not aware of the staffing plan review requirement and had not completed or documented a review of the facility staffing needs. The licensee's STAFFING, DIRECT-CARE STAFFING PLAN & DAILY SCHEDULE policy, effective April 28, 2025, indicated, "5. The staffing plan will be evaluated for the appropriately of staffing levels in the facility and revised as needed at a minimum of two times per year." No further information was provided.	0 470		

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0 470	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 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	0 480		

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	41263	A. BUILDING: _____ B. WING _____	09/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

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0 480	Continued From page 12 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 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:	0 480		

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0 480	Continued From page 13 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 9, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term	0 550		

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0 550	Continued From page 14 Care (OOLTC), the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). 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 September 8, 2026, at 10:51 a.m., the surveyor toured the assisted living facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The licensee lacked a posting of the licensee's grievance form and contact information including the name, email, and phone number for the contact person for the individual responsible for handling resident grievances. Also, the licensee had the OOLTC, OMHDD, and MAARC information only posted in a locked medication closet not visible to residents or visitors. On September 8, 2026, at 10:53 a.m., LALD/CNS-A stated she was not aware the grievance procedure was to be posted with the required information. Also, LALD/CNS-A verbalized she did not know the Ombudsman, and MAARC information was to be posted in a conspicuous area of the facility. Finally, LALD-CNS-A stated she planned to get the	0 550		

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0 550	Continued From page 15 required information posted for residents and visitors. The licensee's Complaint Policy and Procedure dated April 28, 2025, indicated, "1. Each resident or resident representative receives written notice of our facility's process for receiving and resolving complaints/grievances. The procedure will also be posted in a conspicuous location. 2. The written notice includes: a. The resident's right to complain to our facility about the services received from our staff; b. The method of submitting a complaint to our facility; and c. A description of the facility's complaint resolution process available to residents d. The name, telephone number and email contact information for the staff person(s) responsible for handling grievances. e. The contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the MN Adult Abuse Reporting Center (MAARC). The notice will state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the MN Department of Health. f. A statement that our facility will not take any action that negatively affects a resident in retaliation for a complaint made or a concern expressed by the resident or the resident's representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 580	Continued From page 16	0 580		
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: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked documentation on quality	0 580		

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0 580	Continued From page 17 management activities to evaluate quality of care. On September 8, 2026, during an entrance conference at 10:08 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had not yet completed or documented any management discussions or meetings about quality improvement. The licensee's Quality Management Plan policy, dated April 28, 2025, indicated, "The Assisted Living Director will oversee and define the facility's Quality Management Program and quality improvement processes. [Licensee] may establish a Quality Council appropriate to the size of the facility, resident population, and complexity of services provided. The purpose of the Quality Council is to monitor quality of care, resident safety, regulatory compliance, and continuous performance improvement within the facility." In addition, included, "Documentation of quality management activity must be available for two years. Information must be available to the commissioner at the time of the survey, investigation, or renewal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=F	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	0 630		

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0 630	Continued From page 18 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 two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 7, 2026, and had diagnoses including cerebral vascular accident (CVA, a stroke), bilateral carotid artery stenosis (narrowing of the arteries in the neck), and type two diabetes. R1's Individualized Service Plan, dated June 12, 2026, indicated R1 received services including assistance with housekeeping, laundry, meals, bathing, dressing/grooming, toileting, transfers/walking, meals, overnight support, blood	0 630		

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0 630	Continued From page 19 pressure monitoring, day program, appointments, transportation, and medication administration. On September 9, 2026, at 5:35 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-D assist R1 with medication administration. R1's record included an Individualized Violence Prevention & Abuse Prevention Plan, dated April 7, 2026. The document lacked the following required content: -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. R2 R2 was admitted on July 1, 2026, and had diagnoses including chronic gout (inflammatory arthritis) of bilateral hands and feet, and hypertension, and history of cerebral infarction (blocked blood vessel causing tissue death). R2's Individualized Service Plan, dated July 7, 2026, indicated R2 received services including assistance with housekeeping, laundry, meals, mobility/fall prevention plan, blood pressure monitoring, day program, and medication administration. R2's record included an Individualized Violence Prevention & Abuse Prevention Plan, dated July 1, 2026. The document lacked the following required content: -the person's susceptibility to abuse by another individual, including other vulnerable adults; -the person's risk of abusing other vulnerable	0 630		

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0 630	Continued From page 20 adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On September 9, 2026, at 7:56 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee's current IAPP process lacked inclusion of the above details, and she would need to update the assessments to align with state regulations. The licensee's Individual Abuse Prevention Plans policy, dated April 28, 2025, indicated, "PROCEDURE: 1. An individual abuse prevention plan is developed for each assisted living resident. 2. Assisted living residents who receive nursing services will have an individual abuse prevention plan based upon the nursing assessment. 3. Assisted living residents who do not receive nursing services a. Will have an individual abuse prevention plan based upon a review of information available to the assisted living staff b. Will have an individual abuse prevention plan created that may be developed by a staff member that is not a licensed nurse. 4. The individual abuse prevention plan will include: a. Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults b. The resident's risk of abusing other vulnerable adults c. Specific measures to minimize the risk of abuse to that person and other vulnerable adults. d. Measure to minimize the risk of self-abuse, if applicable 5. Abuse prevention plans will be completed by	0 630		

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0 630	Continued From page 21 day-14 of an initial assessment. 6. Abuse prevention plans will be reviewed every 90-days and revised as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 an annual TB Facility Risk Assessment, screening for active TB including history and symptom screening, and baseline	0 660		

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0 660	Continued From page 22 testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) for four of four employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, unlicensed personnel (ULP)-B, ULP-C, and owner/ULP (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: On September 8, 2026, at 10:08 a.m., during the entrance conference, LALD/CNS-A stated she was not aware of the required TB facility risk assessment worksheet to be completed annually. The licensee lacked a completed annual TB Facility Risk Assessment. The licensee's Monthly Calendar Employee Schedule dated August 23, 2026, to October 3, 2026, indicated LALD/CNS-A, ULP-B, ULP-C, and O/ULP-D were all currently scheduled to work shifts at the facility. LALD/CNS-A LALD/CNS-A was hired March 1, 2025, and provided direct nursing care for residents, and supervision of staff. On September 9, 2026, at 7:24 a.m., the surveyor observed LALD/CNS-A assist R1 with blood	0 660		

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0 660	Continued From page 23 glucose monitoring using a continuous blood glucose meter, and insulin administration. LALD/CNS-A's employee record lacked: -a TB history and symptom screening; and -baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA- TB blood test). ULP-B ULP-B was hired May 14, 2026, and provided direct care and services to residents. ULP-B's employee record included a one-step TST dated May 14, 2026, but lacked: -a TB history and symptom screening; and -baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA-TB blood test). ULP-C ULP-C was hired June 15, 2026, and provided direct care and services to residents. ULP-C's employee record included a one-step TST dated July 15, 2026, but lacked: -a TB history and symptom screening; and -baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA-TB blood test). O/ULP-D O/ULP-D was hired March 1, 2025, and provided direct care and services to residents. On September 9, 2026, at 5:35 a.m., the surveyor observed O/ULP-D assist R1 with medication administration. O/ULP-D's employee record included a one-step	0 660		

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0 660	Continued From page 24 TST dated April 29, 2026, but lacked: -a TB history and symptom screening; and -baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA-TB blood test). On September 8, 2026, at 11:46 a.m., LALD/CNS-A stated she might have a TB blood test with a secondary employer and planned to see if she could obtain a copy to place in her employee file. -at 12:01 p.m., LALD/CNS-A stated she was not aware a two-step TST was required to be completed for all employees upon hire and ULP-B, ULP-C, O/ULP-D only had a one-step TST completed. Also, LALD/CNS-A verbalized she was not aware of the required TB history and symptom screening to be completed upon hire. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and Health Care Worker (HCW) education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employees' record. The licensee's 8.16 Tuberculosis Screening policy, dated June 2021, indicated, "Staff whose	0 660		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 25 essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." 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	0 680		

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	41263	A. BUILDING: _____ B. WING _____	09/11/2026

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0 680	Continued From page 26 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. 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:	0 680		

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0 680	Continued From page 27 On September 8, 2026, at 1:00 p.m., the surveyor requested to review the licensee's EPP binder. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had not yet created a facility EPP available to all staff with all the required content according to Appendix Z. The licensee lacked an EPP with the following required content: -establishment of the EPP; -develop and maintain the EPP; -maintain and annual EPP updates; -EPP resident population; -process for emergency preparedness collaboration; -policies and procedures for development of EPP; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking of staff and residents; -policies and procedures including evacuation; -policies and procedures for sheltering in place; -policies and procedures for medical documents; -policies and procedures for volunteers; -policies and procedures for arrangements with other facilities; -policies and procedures for roles under a waiver declared by secretary; -development of a communication plan; -names and contact information; -emergency officials contact information; -primary and alternate means for communication; -methods for sharing information; -procedure for sharing information on occupancy and or needs; -long term care family notifications; -EPP training and testing; -EPP training program; and -emergency prep testing requirements.	0 680		

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0 680	Continued From page 28 On September 8, 2026, at 1:00 p.m., LALD/CNS-A stated the licensee was still working on updating their EPP to be compliant with state requirements. LALD/CNS-A verbalized the licensee had not yet developed an EPP binder to be available to employees in case of an emergency and she was not familiar with the Appendix Z required information. The licensee's Emergency and Disaster Preparedness policy, dated April 28, 2025, indicated, Procedure: 1. An assessment of safety risks has been completed and documented to identify the most probable emergency situations that may be experienced by this facility or community. 2. An assisted living facility with dementia care must include an assessment of safety risks on and around the property. The risks indicated on the assessment must be assessed and mitigated to protect the residents from harm; 3. Based on the assessment, an Emergency Preparedness Plan has been developed. 4. The Emergency Preparedness Plan addresses the following requirements: (a) It is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (b) Includes strategies for addressing emergency events identified by the risk assessment. (c) Addresses our resident population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. (d) Includes a process for cooperation and collaboration with local, tribal, regional, State, or	0 680		

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0 680	Continued From page 29 Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. (e) The emergency disaster plan 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. 5. A written Communication Plan is complete that addresses the elements listed in 42 C.F.R. §483.73(c). 6. Our facility has developed and implements emergency preparedness policies and procedures in compliance with 42 C.F.R. §483.73(c). 7. A written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110. 8. The facility will post the emergency disaster plan prominently. 9. The facility provides building emergency exit diagrams to all residents. 10. Emergency exit diagrams are posted on each floor. 11. Training and Exercises. (a) The facility provides training in emergency and disaster preparedness policies and procedures to all staff during the initial staff orientation and annually thereafter and makes 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. (b) Training is provided to individuals providing services under arrangement, and volunteers, consistent with their roles. (c) The facility conducts exercises to test the Emergency Preparedness Plan at least twice per year in compliance with 42 C.F.R. §483.73(d)(2).	0 680		

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0 680	Continued From page 30 12. The emergency operations plan, communications plan, and the policies and procedures listed above will be reviewed and updated at least annually." Minnesota Administrative Rule 4659.0100 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 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	0 730		

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0 730	Continued From page 31 records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included accurate documentation that services had been provided as identified in the service plan for two of two residents (R1, R2).	0 730		

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0 730	Continued From page 32 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 7, 2026, and had diagnoses including cerebral vascular accident (CVA, a stroke), bilateral carotid artery stenosis (narrowing of the arteries in the neck), and type two diabetes. R1's Individualized Service Plan, dated June 12, 2026, indicated R1 received services including assistance with housekeeping (daily), laundry (two times weekly), meals (three meals daily and snacks), bathing (daily), dressing/grooming (daily), toileting (daily), transfers/walking (each transfer), overnight support (per RN assessed schedule), blood pressure monitoring (daily), day program (up to four times weekly), activities (daily), and medication administration (daily as ordered). R1 ' s signed Department of Human Services Support Plan (DHS SP) dated May 1, 2026, through April 30, 2026, indicated the following authorized elderly waiver services: light housekeeping 0.25 hours/week, heavy housekeeping 0.25 hours/week, personal laundry 0.75 hours/week, linen laundry 0.75 hours/week, three meals and two snacks daily, assistance making appointments 0.5 hours/month, dressing	0 730		

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0 730	Continued From page 33 0.5 hours/day, grooming 0.25 hours/day, bathing 0.5 hours/day, medication administration 0.25 hours/day, insulin injections 0.1 hours/day, behavior support level I and level II, 2 hours/day, and adult day services 34.75 hours/month. On September 9, 2026, at 7:24 a.m., the surveyor observed LALD/CNS-A assist R1 with blood glucose monitoring using R1's continuous blood glucose meter and insulin administration. R1's record lacked documentation any of the following daily and weekly care services were provided as indicated in the service plan, or the reason the services were not provided: -housekeeping, laundry, meals, bathing, dressing/grooming, toileting, transfers/walking, overnight support, activities and day program. R2 R2 was admitted on July 1, 2026, and had diagnoses including chronic gout (inflammatory arthritis) of bilateral hands and feet, and hypertension, and history of cerebral infarction (blocked blood vessel causing tissue death). R2's Individualized Service Plan, signed July 7, 2026, indicated R2 received services including assistance with housekeeping (daily), laundry (two times weekly), meals (three meals daily and snacks), bathing (daily), dressing/grooming (twice daily), toileting assist (daily), transfers/walking (each episode), blood pressure monitoring (daily), day program (three times weekly), activities (daily), and medication administration (daily as ordered). R2 ' s signed DHS SP dated July 22, 2026, through June 30, 2027, lacked a breakdown of individual services and indicated the following	0 730		

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0 730	Continued From page 34 authorized elderly waiver services: community first services and supports 360 minutes per day (24 units/day) to address communication, eating and meal preparation, health interventions, household management, learning, meaningful activities, memory and cognition, movement, personal cares psychosocial health, and self-preservation. Adult day services was authorized (15 minutes), without a total amount. R2's record lacked documentation any of the following daily care services were provided as indicated in the service plan, or the reason the services were not provided: -housekeeping, laundry, meals, bathing, dressing/grooming, toileting assistance, transfers/walking, activities, and day program. On September 9, 2026, at 7:17 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee or employees were not currently documenting any daily care services being provided. LALD/CNS-A verbalized the only care the employees documented were medications for R1 and R2, and treatments ordered for R1. Also, LALD/CNS-A stated she was still trying to decide whether she would create a spreadsheet of the daily cares for each resident for employees to document on or if she would purchase an electronic medical record. The licensee's Resident Records policy, dated April 28, 2025, indicated under number 3, "The resident record will contain: i. Documentation that services have been provided as identified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 730		

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0 730	Continued From page 35 (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 790		

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0 790	Continued From page 36 Environment Inspection Report (PEIR) dated Septemeber 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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).	0 800		

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0 800	Continued From page 37 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 8, 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=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 38 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 8, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01370	Continued From page 39	01370		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41263	A. BUILDING: _____ B. WING _____	09/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

(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
01370	Continued From page 40 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure training and competencies required for all ULPs were completed with all required content for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 8, 2026, at 10:08 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she completed the initial training, and determined the competency of her employees. Also, LALD/CNS-A verbalized the licensee's orientation and training program was still in the process of being developed. ULP-B and ULP-C were hired on May 14, 2026, and June 15, 2026, respectively, to provide direct care services to residents of the assisted living facility. The licensee's posted Monthly Calendar Employee Schedule dated August 23, 2026, to	01370		

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01370	Continued From page 41 October 3, 2026, indicated ULP-B worked August 26 (evening shift), September 2 (afternoon shift), and 4 (evening shift). The schedule indicated ULP-C worked August 31 (evening shift). ULP-B and ULP-C's employee records both lacked documentation of training and competency evaluations required for all ULP including: -care and use of hearing aids; -training on the prevention of falls; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology equipment and assistive devices. On September 8, 2026, at 12:33 p.m., LALD/CNS-A stated she was in the process of redoing the power point she used to complete training with her employees. LALD/CNS-A acknowledged there were some required items that she was not familiar with and some may have been missing with employees or were in the process, so she verbalized she planned to update the licensee's training program to include all the required content. The licensee's Assisted Living Orientation - ULP Staff policy, dated April 28, 2025, indicated, "PROCEDURE: 4. Training for ULPs who are not NARs. In addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: a. Person-centered care and service delivery including how they apply to direct support services	01370		

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01370	Continued From page 42 b. Documentation requirements for services provided c. Changes of condition i. Observation ii. How and where to report d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal hygiene and grooming f. Fall prevention g. Basic nutrition h. Meal preparation i. Food safety j. Assistance with eating k. Preparation of modified diets as ordered by a licensed health professional l. Communication skills including i. Preserving dignity of the resident ii. Showing respect for the resident, resident preferences, cultural background, and family m. Confidentiality and privacy n. Appropriate boundaries between staff, residents, and resident families o. Commonly used health technology equipment and assistive devices p. Observing, reporting, and documenting resident status q. Basic knowledge of i. Body functioning ii. Changes in body functioning iii. Injuries or other observed changes that must be reported to appropriate personnel r. Recognizing physical, emotional, cognitive and developmental needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 43	01380		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required for unlicensed personnel (ULP) providing assisted living services for two of two employees (ULP-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01380		

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01380	Continued From page 44 The findings include: On September 8, 2026, at 10:08 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she completed the initial training, and competencies with her employees. Also, LALD/CNS-A verbalized the licensee's orientation and training was in the process of being developed. ULP-B and ULP-C were hired on May 14, 2026, and June 15, 2026, respectively, to provide direct care services to residents of the assisted living facility. The licensee's posted Monthly Calendar Employee Schedule dated August 23, 2026, to October 3, 2026, indicated ULP-B worked August 26 (evening shift), September 2 (afternoon shift), and 4 (evening shift). The schedule indicated ULP-C worked August 31 (evening shift). ULP-B and ULP-C's employee records both lacked documentation of training and competency evaluations on the following topic: -recognizing physical, emotional, cognitive, and developmental needs of the resident. On September 8, 2026, at 12:33 p.m., LALD/CNS-A stated she was in the process of redoing the power point she used to complete training with her employees. LALD/CNS-A acknowledged there were some required items that she was not familiar with and some may have been missing with employees or were in the process, so she verbalized she planned to update the licensee's training program to include all the required content.	01380		

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01380	Continued From page 45 The licensee's Assisted Living Orientation - ULP Staff policy, dated April 28, 2025, indicated, "PROCEDURE: 4. Training for ULPs who are not NARs. In addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: a. Person-centered care and service delivery including how they apply to direct support services b. Documentation requirements for services provided c. Changes of condition i. Observation ii. How and where to report d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal hygiene and grooming f. Fall prevention g. Basic nutrition h. Meal preparation i. Food safety j. Assistance with eating k. Preparation of modified diets as ordered by a licensed health professional l. Communication skills including i. Preserving dignity of the resident ii. Showing respect for the resident, resident preferences, cultural background, and family m. Confidentiality and privacy n. Appropriate boundaries between staff, residents, and resident families o. Commonly used health technology equipment and assistive devices p. Observing, reporting, and documenting resident status q. Basic knowledge of i. Body functioning ii. Changes in body functioning iii. Injuries or other observed changes that	01380		

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01380	Continued From page 46 must be reported to appropriate personnel r. Recognizing physical, emotional, cognitive and developmental needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 47 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing assisted living services to residents for two of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, and unlicensed personnel (ULP)-C).	01470		

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01470	Continued From page 48 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: LALD/CNS-A LALD/CNS-A was hired March 1, 2025, and provided direct nursing care to residents, and supervision of staff. On September 9, 2026, at 7:24 a.m., the surveyor observed LALD/CNS-A assist R1 with blood glucose monitoring using a continuous blood glucose meter, and insulin administration. LALD/CNS-A's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -an overview of the Assisted Living statutes 144G and rules; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff	01470		

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01470	Continued From page 49 responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. ULP-C ULP-C was hired June 15, 2026, and provided direct care services to residents. ULP-C's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: -an overview of the Assisted Living statutes 144G and rules; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

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01470	Continued From page 50 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On September 8, 2026, at 11:30 a.m., LALD/CNS-A stated she did not have her own employee file, and she was not aware it was required for her to keep an employee record for herself, including all the required content. LALD/CNS-A verbalized she would look to see if she was able to obtain some documented training, she completed as part of her LALD training. On September 8, 2026, at 12:33 p.m., LALD/CNS-A stated she was in the process of creating her training program for new employees and there are portions of the required orientation training that has not been completed yet for the licensee's employees and this is why the training documents of ULP-C were only partially completed. The licensee's Assisted Living & Assisted Living with Memory Care Orientation- All Staff policy, dated April 28, 2025, indicated, "2. At minimum, orientation must include the following topics: a. An overview of Minnesota's assisted living law b. An introduction and review of agency policies and procedures related to the provision of assisted living services c. Emergency and disaster training -Handling of emergencies and use of emergency services -Emergency and disaster preparedness plan -Procedures to use in handling various	01470		

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01470	Continued From page 51 emergency situation d. Employee Right to Know e. The assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights f. Infection control -Bloodborne pathogens -Maintaining a clean and safe environment -TB prevention and control -Basic infection control g. HIPAA / Privacy Practices h. Employee job description i. Organizational chart and roles of staff within the facility j. Principles of person-centered planning and service delivery and how they apply to direct support services k. Types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure l. Maltreatment of vulnerable adults m. How to report maltreatment of vulnerable adults n. How to report a crime o. Complaint process -Handling resident complaints -The facility's system for receiving and responding to complaints, -Where and how to report complaints -Contact information for the Office of Health Facility Complaints -Contact information for the Office of the Ombudsman for long-term care -Contact information for the Office of the Ombudsman for Mental Health and Disabilities 3. Quality Management 4. Handling resident's finance and property 5. Dementia Training 6. Medicaid Funding	01470		

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01470	Continued From page 52 a. Medicaid Fraud and Abuse b. Rights -home and community-based services settings rule residential providers." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on	01530		

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01530	Continued From page 53 topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care training and two hours of initial mental illness and de-escalation training were conducted within 120 working hours of the employment start date for one of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-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 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: LALD/CNS-A began employment on March 1, 2025, and provided direct nursing care services and supervision for R1 who was admitted on April 7, 2026.	01530		

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	41263	A. BUILDING: _____ B. WING _____	09/11/2026

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01530	Continued From page 54 LALD/CNS-A's employee record lacked documentation she completed the required eight hours of initial dementia care training and two hours of initial training on mental illness and de-escalation topics within 120 hours of start date. On September 8, 2026, at 11:30 a.m., LALD/CNS-A stated she thought she had completed all the required training with her LALD training but would look to see if she could find specific documentation of the required dementia care training hours and required mental health and de-escalation training. LALD/CNS-A verbalized she had not created an employee record for herself yet. On September 10, 2026, at 2:39 p.m., LALD/CNS-A responded to the surveyor, via email, "a. Our facility is now contracted with [online learning provider] to provide ongoing training b. All I can find are certificates of completion from the LeadingAge program, an example was shown to you during the entrance interview." The licensee's Assisted Living Dementia, Mental Illness, and De-escalation Training policy, effective April 28, 2025, indicated, "2. Assisted Living licensed settings A. Orientation i. Supervisors of direct-care staff will: 1. complete a minimum of 8 hours initial training on dementia care topics and 2 hours of initial training on mental illness and de-escalation topics 2. initial training will be completed within 120 working hours of the employment start date. ii. Direct-care staff will complete 1. a minimum of 8 hours of initial training on	01530		

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01530	Continued From page 55 dementia care topics and 2 hours of initial training on mental illness and de-escalation topics. 2. initial training will be completed within 160 working hours of the employment start date. iii. Non-direct care staff will 1. complete a minimum of 4 hours initial training on dementia care topics and 2 hours of initial training on mental illness and de-escalation topics. 2. initial training will be completed within 160 working hours of the employment start date. iv. Dementia care training will include: 1. An explanation of Alzheimer's disease and other dementias 2. Assistance with activities of daily living 3. Problem solving with challenging behaviors 4. Communication skills 5. Person-centered planning and service delivery v. Mental illness and de-escalation technique topics will include: 1. Recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor related disorders, personality and psychotic disorders, substance use disorder, and substance misuse 2. de-escalation techniques and communication; and 3. crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01730	Continued From page 56	01730		
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 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	01730		

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01730	Continued From page 57 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 develop and maintain an individualized medication management plan for each resident to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on July 1, 2026, and had diagnoses including chronic gout (inflammatory arthritis) of bilateral hands and feet, and hypertension, and history of cerebral infarction (blocked blood vessel causing tissue death). R2's Individualized Service Plan, dated July 7, 2026, indicated R2 received services including assistance with housekeeping, laundry, meals, mobility/fall prevention plan, blood pressure monitoring, day program, and medication administration.	01730		

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01730	Continued From page 58 On September 9, 2026, at approximately 8:00 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner/unlicensed personnel (O/ULP)-D interacting with R2 and ensuring he had everything he needed and was ready to have transportation pick him up to go to adult day care. R2's record included a Master Uniform Assessment Form dated July 15, 2026, under section five, Medication Review, noted, "Staff administer all medications according to the current signed MAR and provider orders. PRN medications are reported but exact PRN names, doses, indications, and parameters must be reconciled before signing. No known allergies are documented on the available face sheet; verify allergies directly and against the current medical record." R2's record lacked an individualized medication management to include the following required content: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -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. On September 9, 2026, at 7:43 a.m., LALD/CNS-A stated she was having difficulty	01730		

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01730	Continued From page 59 getting R2 go to his medical provider and so she had not yet completed an individualized medication management plan for R2. The licensee's Individualized Medication, Treatment & Therapy Management Plan policy, dated April 28, 2025, indicated, "5. Medication Management Plans: RN will develop a medication management plan for each resident receiving medication management services. The medication management plan will include: a. Statement of the medication management services provided to the resident b. Description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring and ensuring timely refills of medications e. Identification of medication management tasks that may be delegated to an unlicensed person. f. Procedure for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. Resident-Specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications used to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01820	Continued From page 60	01820		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there were current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16 a, for all prescribed medications that the assisted living facility was managing for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on April 7, 2026, and had diagnoses including cerebral vascular accident (CVA, a stroke), bilateral carotid artery stenosis (narrowing of the arteries in the neck), and type two diabetes. R1's Individualized Service Plan, dated June 12, 2026, indicated R1 received services including	01820		

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01820	Continued From page 61 assistance with housekeeping, laundry, meals, bathing, dressing/grooming, toileting, transfers/walking, meals, overnight support, blood pressure monitoring, day program, appointments, transportation, and medication administration. R1's medication administration record (MAR) dated September 2026, indicated R1 received assistance with administration of the following scheduled medications: -Aspirin (for pain and blood thinner) 80 milligrams (mg), oral in the morning; -Jardiance (to lower blood glucose) 25 mg, oral in the morning; -cetirizine (for allergies) hydrochloride (HCL), 10 mg, oral in the morning; -famotidine (to reduce stomach acid to treat and prevent heartburn) 20 mg, oral in the morning, and evening; -Vitamin B (a supplement) 1000 micrograms (mcg), oral in the morning; -atorvastatin (to lower bad cholesterol) 80 mg, oral in the evening; -Tylenol (for pain and fever) 325 mg times 3, oral at bedtime; -trazadone (for depression or insomnia) 25 mg, oral at bedtime; -pregabalin (to treat nerve pain) 25 mg, oral at bedtime; -duloxetine (for depression) 20 mg times 2, oral at bedtime. In addition, R1's record included a Diabetes document dated August 2026, indicated R1 received assistance with administration of the following insulin medications: -Novolog (insulin aspart, rapid acting) 4 units daily at breakfast, lunch, and dinner; abdominal site injection; and -Lantus (long-acting insulin) 20 units daily at bedtime, abdominal site injection.	01820		

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01820	Continued From page 62 R1's record lacked a current written or electronically recorded prescription for all the above medications. R2 R2 was admitted on July 1, 2026, and had diagnoses including chronic gout (inflammatory arthritis) of bilateral hands and feet, and hypertension, and history of cerebral infarction (blocked blood vessel causing tissue death). R2's Individualized Service Plan, dated July 7, 2026, indicated R2 received services including assistance with housekeeping, laundry, meals, mobility/fall prevention plan, blood pressure monitoring, day program, and medication administration. R2's record included a medication administration record (MAR) dated September 2026, and indicated R2 received assistance with the following medications: -colchicine (to reduce inflammation) 0.6 mg, oral in the evening; -allopurinol (to lower uric acid to reduce gout attacks) 100 mg, oral in the evening; -lisinopril (for high blood pressure) 10 mg, oral in the evening; -febuxostat (to lower uric acid levels) 40 mg, oral in evening; and -Tylenol (for pain) 325 mg x 2, oral in the evening. R2's record included a document titled Physician Medication Order Sheet, dated July 15, 2026. R2's Physician Medication Order Sheet included a signature by LALD/CNS-A, but R2's record lacked a current written or electronically recorded prescription for all the above medications.	01820		

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01820	Continued From page 63 On September 9, 2026, at 7:25 a.m., LALD/CNS-A stated she did not have signed provider orders for R1 and R2. LALD/CNS-A verbalized she communicated regularly with the resident's providers, but she had been unable to get signed medication orders for R1 and R2. The Office of the Revisor of Statutes defined 151.01 Subd. 16 a., "Prescription. "Prescription" means a prescription drug order that is written or printed on paper, an oral order reduced to writing by a pharmacist, or an electronic order. To be valid, a prescription must be issued for an individual patient by a practitioner within the scope and usual course of the practitioner's practice, and must contain the date of issue, name and address of the patient, name and quantity of the drug prescribed, directions for use, the name and address of the practitioner, and a telephone number at which the practitioner can be reached. A prescription written or printed on paper that is given to the patient or an agent of the patient or that is transmitted by fax must contain the practitioner's manual signature. An electronic prescription must contain the practitioner's electronic signature." The licensee's Medication & Treatment Orders: Receiving, Renewal, Implementation, and Reordering policy, effective April 28, 2025, indicated, "POLICY: -All medication and treatments will have an appropriate prescriber {sic} order in the resident's record. -A licensed nurse will be updated on the receipt of all orders in a timely fashion. -All medication and treatment orders will be renewed by a prescriber annually or more frequently as needed." Also, included, "PROCEDURE: 2. Orders will be	01820		

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01820	Continued From page 64 obtained either in writing, verbally, or electronically with a legal electronic signature, by licensed prescriber. 3. All medication and treatment orders must be signed by the prescriber either by hand or by a legal electronic signature." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of the medication refrigerator to ensure medications were stored per manufacturer directions for one of one resident (R1) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01880		

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01880	Continued From page 65 The findings include: R1 had diagnoses including cerebral vascular accident (CVA, a stroke), bilateral carotid artery stenosis (narrowing of the arteries in the neck), and type two diabetes R1's Service Plan dated June 12, 2026, indicated R1 received services including medication administration, insulin, assistance/supervision with activities of daily living (ADLs), overnight support, and day program up to four times weekly; days times per current authorization and program schedule. Additionally, under Self-administration "Insulin self-administration at Adult Day Program". Under Medication safeguards "Do not administer an unclear, discontinued, expired, contaminated, or improperly stored medication. Contact RN/pharmacy". R1's medication administration record (MAR) titled Diabetes dated September 2026, indicated to record R1's blood glucose and to administer Novolog (insulin aspart) four units, into an abdominal site at breakfast, lunch and dinner. On September 9, 2026, at 6:00 a.m., during a medication storage tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed R1's insulin in a locked compartment within the main refrigerator in the kitchen. The refrigerator had no internal thermometer nor a free-standing thermometer. LALD/CNS-A stated there was no temperature monitoring or records to ensure they stored R1's insulin in accordance with the manufacturer's guidelines. R1's Novolog (a rapid acting insulin) FlexPen	01880		

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01880	Continued From page 66 prescription box dated April 7, 2026, indicated, "Store refrigerated at 2°C [degrees Celsius] to 8°C. (36°F [degrees Fahrenheit] to 46°F) until first use. After first use store at room temperature (up to 30°C [86°F]) and discard after 28 days. Avoid freezing. Protect from light." The licensee's Storage of Medications policy, dated April 28, 2025, indicated, 2. "Proper Storage of Medications a. The RN will recommend where medications should be stored understanding that [licensee] may not be able to control where and how a resident stores his/her medications in their room. The RN will provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and the nursing office." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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01890	Continued From page 67 by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date for one of one resident (R1) who received insulin. 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 had diagnoses including cerebral vascular accident (CVA, a stroke), bilateral carotid artery stenosis (narrowing of the arteries in the neck), and type two diabetes R1's Service Plan dated June 12, 2026, indicated R1 received services including assistance with medication administration, insulin, assistance/supervision with activities of daily living (ADLs), overnight support and day program up to four times weekly; days times per current authorization and program schedule. Additionally, under Self-administration "Insulin self-administration at Adult Day Program". Under Medication safeguards, "Do not administer an unclear, discontinued, expired, contaminated, or improperly stored medication. Contact RN/pharmacy". R1's medication administration record (MAR), titled Diabetes, dated September 2026, indicated to record R1's blood glucose and to administer	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41263	A. BUILDING: _____ B. WING _____	09/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 68 Novolog (insulin aspart, a rapid acting insulin) four units, into an abdominal site at breakfast, lunch and dinner. On September 9, 2026, at 6:00 a.m., the surveyor observed insulin storage with licensed assisted living director/clinical nurse specialist (LALD/CNS)-A. A clear plastic sandwich sized bag with R1's name on the front; contained one Novolog insulin pen. The pen lacked a date when opened and lacked a prescription label with legible information including the expiration or beyond-use date of a time-dated drug. LALD/CNS-A stated this insulin pen was for use at R1's adult day program. A second clear plastic sandwich size bag with R1's name on the front; contained one Novolog insulin pen which was dated when opened on August 24, 2026, however, lacked a prescription label with legible information. LALD/CNS-A stated this insulin pen was for use by the licensee. Also, LALD/CNS-A stated there would not be a way to verify when the medication was opened if it was not dated and she would need to order pharmacy labels to affix to the insulin pens to ensure all information was available to the caregivers who administered insulin. On September 9, 2026, at 7:24 a.m., the LALD/CNS-A checked R1's blood glucose on R1's Dexcom (continuous blood glucose meter). The LALD/CNS-A then prepared and administered R1's four units of Novolog insulin, using the undated insulin pen that was identified for use at the day program, was not dated when opened and without a prescription label. When surveyor asked the LALD/CNS-A if the insulin was safe to give without an open date or pharmacy label, she said she knew.	01890		

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	41263	A. BUILDING: _____ B. WING _____	09/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 69 The Novolog Storage instructions dated May 2026, indicated: -Keep at room temperature (below 86°F (degrees Fahrenheit) or refrigerate for up to 28 days, -Keep away from direct heat and light; and -Dispose after 28 days, even if there is insulin left in the pen or vial. The licensee's Storage of Medications policy, dated April 28, 2025, indicated, "2. Proper Storage of Medications a. The RN will recommend where medications should be stored understanding that our agency may not be able to control where and how a resident stores his/her medications in their room. The RN will provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and the nursing office. b. Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. c. An over-the-counter drug must be kept in the original labeled container." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41263	A. BUILDING: _____ B. WING _____	09/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment and therapy management record including clear instructions developed by	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41263	A. BUILDING: _____ B. WING _____	09/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

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01940	Continued From page 71 the registered nurse (RN) for delegated blood glucose testing and insulin administration with all required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on April 7, 2026, and had diagnoses including cerebral vascular accident (CVA, a stroke), bilateral carotid artery stenosis (narrowing of the arteries in the neck), and type two diabetes. R1's Individualized Service Plan, dated June 12, 2026, indicated R1 received services including assistance with housekeeping, laundry, meals, bathing, dressing/grooming, toileting, transfers/walking, meals, overnight support, blood pressure monitoring, day program, appointments, transportation, and medication administration. R1's Individualized Medication Management Plan (IMMP) dated August 4, 2026, indicated, "3. Diabetes/ Insulin Management -Monitor blood glucose/Dexcom [a continuous glucose monitor] readings according to current orders and the care plan. -Administer insulin only according to the current prescriber order, MAR [medication administration record], and RN delegation. -Follow all current insulin parameters,	01940		

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	41263	A. BUILDING: _____ B. WING _____	09/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

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01940	Continued From page 72 correction/sliding-scale instructions, and hold parameters exactly as ordered. -Never independently change an insulin dose. -Document blood glucose readings and insulin administration in the appropriate resident record. -Observe for signs or symptoms of hypoglycemia [low blood sugar level] and hyperglycemia [high blood sugar level] and follow [R1's] current protocol. -Notify the RN/prescriber according to ordered parameters and facility policy; use emergency procedures when indicated. Current BG [blood glucose] monitoring schedule: Before Meals, Bedtime, Overnight Specific insulin/notification/hold parameters: Hold if < 70." R1's record included a medication administration record (MAR) titled Diabetes, dated September 2026. The MAR identified instructions to administer Novolog (insulin aspart, a rapid-acting insulin) four units abdominally three times per day (breakfast, lunch, dinner) and to record the blood sugar level. R1's record lacked clear parameters and instructions by the nurse for when a caregiver should notify the nurse during blood glucose monitoring and insulin administration. On September 9, 2026, at 6:47 a.m., the surveyor observed O/ULP-D assist R1 with blood glucose monitoring. O/ULP-D checked the continuous blood glucose meter and stated the blood glucose reading was 138. The surveyor asked what normal parameters were for blood sugars, what actions to take if R1's blood sugar is too high or too low, or when he should hold R1's insulin. O/ULP-D reviewed R1's insulin MAR and stated he would not know what normal parameters were	01940		

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01940	Continued From page 73 for blood sugars nor what actions he would take if R1's blood sugar was too high or too low, or when he would hold insulin. O/ULP-D was not aware of the low-range parameters identified in R1's Individualized Medication Management Plan. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's blood sugars were currently stable, and there were no parameters in place. The licensee's Delegation of Nursing Tasks policy effective April 28, 2025, indicated, "4. Steps Prior to Delegating Administration of Treatments and Therapy. Treatments or therapy tasks may be delegated or assigned by a Licensed Health Professional to unlicensed personnel according to the Licensed Health Professional's applicable licensing practice standards. When a treatment or therapy is delegated or assigned to unlicensed personnel, the RN or authorized Licensed Health Professional must: a. Develop and maintain a current individualized treatment or therapy management record for each resident that addresses the requirements of MN Statutes 144.4793, subd. 3. b. Instruct the unlicensed personnel in the proper methods to provide the treatment or perform the task with respect to each resident and determine that the unlicensed personnel have demonstrated the ability to competently follow the procedures; c. Develop written specific instructions for each resident and document those instructions in the resident's record; and d. Communicated with the unlicensed personnel about the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		

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01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure written or electronically recorded treatment orders were maintained for one of one resident who received blood sugar checks (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 September 8, 2026, at approximately 10:00 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated one resident (R1) received assistance with blood glucose monitoring. R1 had diagnoses including cerebral vascular accident (CVA, a stroke), bilateral carotid artery	01970		

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01970	Continued From page 75 stenosis (narrowing of the arteries in the neck), and type two diabetes. R1's Service Plan dated June 12, 2026, indicated R1 received services including assistance with medication administration, blood glucose monitoring as ordered, insulin, assistance/supervision with activities of daily living (ADLs) and overnight support. R1's record included a blood sugar documentation flow sheet for September 2026. The record indicated blood glucose levels were documented three times daily unless R1 refused or self-administered. R1's record lacked signed provider orders for blood glucose testing frequency. On September 9, 2026, at 6:17 a.m., LALD/CNS-A stated she did not have signed orders from R1's provider for blood glucose testing frequency. On September 9, 2026, at 7:24 a.m., the surveyor observed LALD/CNS-A assist R1 with blood glucose monitoring using R1's Dexcom (continuous blood glucose meter) and insulin administration. The licensee's Medication & Treatment Orders: Receiving, Renewing, Implementation and Reordering, dated April 28, 2025, indicated, "Policy: - All medication and treatments will have an appropriate prescriber {sic} order in the resident's record. - A licensed nurse will be updated on the receipt of all orders in a timely fashion. - All medication and treatment orders will be	01970		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

(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
01970	Continued From page 76 renewed by a prescriber annually or more frequently as needed. Procedure: 1. A licensed nurse, or other individual qualified to receive orders will obtain medication and treatment orders. 2. Orders will be obtained either in writing, verbally, or electronically with a legal electronic signature, by licensed prescriber. 3. All medication and treatment orders must be signed by the prescriber either by hand or by a legal electronic signature. 4. All medication and treatment orders or medication and treatment order renewals will be signed and placed in the resident's record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility, including statutory language to disclose electronic monitoring activity, potentially affecting all current	03090		

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SILVER MEADOWS ASSISTED LIVING	813 MEYER STREET N MAPLEWOOD, MN 55119

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03090	Continued From page 77 residents in the assisted living facility, staff, and any visitors to 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 September 8, 2026, at 10:55 a.m., during a facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, electronic monitoring cameras were observed in various locations within the licensee's facility. No electronic monitoring notice was posted as required. LALD/CNS-A stated she had not posted the electronic monitoring notice yet. On September 10, 2026, at 3:08 p.m., LALD/CNS-A stated, via email, the facility had five individual medical devices and five cameras. The licensee's Electronic Monitoring Policy and Procedure dated January 1, 2020, indicated, " 4. [Licensee] shall post a sign at each facility entrance accessible to visitors that states, 'Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities.'" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

SILVER MEADOWS ASSISTED LIVING
813 MEYER STREET N
Maplewood, MN 55119
Ramsey County
Parcel:

Phone:

License Info

License: HFID 41263

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

Inspection Info

Report Number: F1021261258
Inspection Type: Full - Single
Date: 9/9/2026 Time: 10:34:29 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
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: NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. DIRECTOR HAS AN APPROVED FOOD SAFETY CERTIFICATE POSTED ON-SITE BUT DID NOT SEND IT TO MDH TO GET THE CFPM CERTIFICATE. INFORMATION ON HOW TO OBTAIN THE CFPM CERTIFCATE SENT WITH REPORT.

Comply By: 10/9/2026 *Originally Issued On: 9/9/2026*

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH DIRECTOR. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 9/10/2026 *Originally Issued On: 9/9/2026*

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: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE. THERMOMETER STICKER LEFT ON-SITE.

Comply By: 9/16/2026 *Originally Issued On: 9/9/2026*

Food & Beverage General Comment

All findings on this report were discussed with Director May Lee. HRD nurse evaluator was not on-site during inspection.

This facility is a residential home, and they currently have 2 clients and the facility can accommodate up to 3 clients.

Food is for same-day service. Leftovers are discarded at the end of service.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

Establishment has a residential dishwasher. A thermolabel was left on-site for staff to use, and they'll e-mail the inspector a photo to confirm the dishwasher is reaching a final utensil surface temperature of at least 160F.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

The kitchen has residential equipment, laminate floor, laminate countertops and painted drywall. Physical facility items will be monitored during future inspections.

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

I acknowledge receipt of the Metro District Office inspection report number F1021261258 from 9/9/2026

Melissa Ramos

May Lee
Director

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

SILVER MEADOWS ASSISTED LIVING
Maplewood
County/Group: Ramsey County

Inspection Info

Report Number: F1021261258
Inspection Type: Full
Date: 9/9/2026
Time: 10:34:29 AM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Whirlpool Kitchen Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Raw Chicken **; Temperature Process:** Thawing
Location: Whirlpool Kitchen Refrigerator at 27 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Whirlpool Kitchen Refrigerator **; Temperature Process:** Ambient Air
Location: Kitchen at 40 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41263001	**Date:** 9/8/2026
Facility Name: Silver Meadows Assisted Living	
Facility Address: 813 Meyer St. N., St. Paul, MN 55119	

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: The fire extinguishers installed throughout the facility were manufactured in 2025. No record of monthly visual inspections by facility staff was provided during the survey. Facility staff indicated they were unaware of requirements for servicing and maintenance for fire extinguishers. Fire extinguishers should be maintained in proper condition and should receive annual servicing from a licensed professional and monthly visual inspection by facility staff. Inspections should be documented and maintained.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **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 ceiling fan installed in resident room 2 was not properly secured to the ceiling and was hanging by its wiring. The fan was very loose and posed a risk of falling onto the bed below. The fan should be securely connected to the ceiling and maintained in proper state of repair.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; 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 are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide an FSEP and indicated that they were in the process of developing procedures, but no documentation had been created for this information. An FSEP should be created with relevant and accurate information regarding fire safety and evacuations for the facility.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: Rooms throughout the facility were not labelled or numbered and documentation provided to the surveyor failed to indicate the location or number of resident rooms. The location and number of resident rooms should be identified and maintained.

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

   Comments: The licensee failed to provide site-specific staff actions for evacuation during a fire or similar emergency. No employee actions were provided to the surveyor and staff indicated that such a policy had not been created. The facility should have a readily accessible FSEP that should include site-specific staff actions for evacuation.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide site-specific resident actions for evacuation during a fire or similar emergency. No resident actions were provided to the surveyor and staff indicated that such a policy had not been created. The FSEP should include site-specific resident actions for evacuation.

5. 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 record of employee training on fire safety and evacuation policies. No record of employee trainings on the FSEP was provided to the surveyor. Staff should receive training on hire and at least twice a year thereafter.

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide record of resident training on fire safety and evacuation policies. No record of resident trainings on the FSEP was provided to the surveyor. Trainings should be provided for residents at least once per year.

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

   Comments: The licensee failed to provide adequate record of evacuation drills. Evacuation drills should occur at least twice per shift per year and at least once every other month.