HEALTH REGULATION DIVISION
NOTICE AND ORDER OF IMMEDIATE TEMPORARY SUSPENSION
AND NOTICE OF REVOCATION

In the Matter of High Drive Customized Assisted Living LLC
13813 High Drive
Burnsville, MN 55337

MDH HFID # **39715**

IT IS ORDERED that the Minnesota Department of Health ("Department" or "MDH") is immediately temporarily suspending the assisted living facility license for HIGH DRIVE CUSTOMIZED ASSISTED LIVING LLC ("High Drive"), license number 425883, for ninety (90) days, under the provisions of Minn. Stat. 144G.20, Subd. 3.

IT IS FURTHER ORDERED that MDH revokes the assisted living facility license for HIGH DRIVE CUSTOMIZED ASSISTED LIVING LLC ("High Drive"), license number 425883, under the provisions of Minn. Stat. 144G.20, Subd. 1.

Facts and Law:

1. Minn. Stat. ch. 144G authorizes the Department to regulate assisted living facilities in Minnesota. This authority includes issuing assisted living facility licenses, conducting surveys to determine compliance with the assisted living laws, and conducting complaint investigations of alleged violations of the assisted living facility laws. The Commissioner of Health is authorized by Minn. Stat. § 144G.20, Subd. 3 to immediately temporarily suspend an assisted living facility license for not more than ninety (90) days if violations are found which "pose an imminent risk of harm to the health or safety of residents." The Commissioner of Health is also authorized to revoke an assisted living facility license pursuant to Minn. Stat. § 144G.20, Subd. 1 if certain conditions occur.

2. On June 16, 2023, MDH issued an assisted living facility license to High Drive, which was renewed most recently effective June 16, 2026.

3. On September 21, 2026, to September 25, 2026, Department surveyors from the Health Regulation Division entered the High Drive facility, HFID 39715 to conduct a survey under Minn. Stat. § 144G.30. The survey findings resulted in twenty-nine (29) total correction orders (deficiencies/violations); there were five (5) Level 3 violations and three (3) Level 4 violations.

    a. A Level 3 citation is 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
    b. A Level 4 citation is a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death

4. As a result of the survey MDH initiated on September 21, 2026, MDH determined the facility violated the following laws:
    a. Minn. Stat. § **144G.41, Subd. 1 (2)**, provide services in a manner that complies with the Nurse Practice Act when the clinical nurse supervisor (CNS) delegated activities to unlicensed personnel (ULP) that required clinical reasoning, nursing judgment, or critical decision making.
        i. Resident (R)-3 had diagnoses that included hypertension, tracheostomy (a surgical opening made through the front of the neck into the windpipe [trachea] to provide a direct airway for breathing) complications, and cognitive deficits following intracranial hemorrhage.
        ii. Although the service plan did not include tracheostomy suctioning, on September 22, 2025, at 12:17 p.m., the surveyor observed ULP-C gather suctioning equipment to use for R3.
        iii. The ULP provided tracheostomy suctioning (procedure used to clear mucous and secretions from an artificial airway to maintain open breathing passages) to R3 three times. The ULP stated the registered nurse (RN) trained and checked their competency of the procedure despite no evidence of this in the employee file.
        iv. The facility Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 15, 2026, indicated the licensee provided tracheostomy suctioning assistance, however, did not have a licensed nurse onsite 24/7.
        v. An undated, unsigned treatment plan indicated R3 will require suctioning two to three times daily and as needed.
    b. Minn. Stat. § **144G.41, Subd. 1 (11-12)**, ensure sufficient staffing to meet the scheduled and reasonably foreseeable unscheduled needs of each resident when the licensee did not do this for two residents (R2 and R3) who required two-person transfers with a mechanical lift. Minnesota Administrative Rule 4659.0180, Subp. 5, further directs, "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan."
        i. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee. R2's assessment dated May 14, 2026, indicated R2 was wheelchair bound and needed daily assist of two with an easy-stand for transfers (type of mechanical lift, a device designed to assist caregivers in safely transferring individuals with limited mobility).
        ii. R3's diagnoses included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. R3's assessment dated May 7, 2026, indicated R3 was wheelchair and bed-bound and needed daily assist of two for Hoyer lift transfers (type of mechanical lift, a device designed to assist caregivers in safely transferring individuals with the inability to stand).

iii. The licensee did not have a current staffing plan. The weekly schedule dated September 20, 2026, to September 26, 2026, indicated staffing requirements for each shift, Sunday through Saturday as follows:
    1. Day shift (7:00 a.m. - 7:00 p.m.), two (2) staff required
    2. Night shift (7:00 p.m. - 7:00 a.m.), one (1) staff required.
iv. The facility's UDALSA, dated January 15, 2026, indicated the number of unlicensed direct care staff typically scheduled per shift as follows:
    1. Day Shift: 1-2 depending on the current needs of the resident
    2. Evening Shift: 1-2 depending on the current needs of the resident
    3. Night Shift: 1-2 depending on the current needs of the resident
v. On September 22, 2026, at 1:20 p.m., the surveyor asked assisted living director/clinical nurse supervisor (LALD/CNS)-A how staff met R3's (reasonably foreseeable and unscheduled) needs from 7:00 p.m. to 7:00 a.m., or what they would do in the case of an emergency. LALD/CNS-A stated the staff would call the "on-call" staff member (ULP-F), who lived "about five miles away" to come to the facility.
vi. Google maps show, depending on which route is used, ULP-F lives anywhere from 27 to 29 miles from the facility.

c. Minn. Stat. § **144G.70, Subd. 2 (c-f)**, comprehensive resident reassessments shall be conducted at least every 90 days; sooner if there is a change in condition, utilizing the uniform assessment tool (MN Rules 4659.0150) when the registered nurse (RN) did not complete timely, comprehensive assessments for all of the residents of the facility.
    i. The facility RN (LALD/CNS-A) utilized two different tools when completing required nursing assessments. No resident received a thorough, comprehensive nursing assessment since their admission to the facility.
        1. The "Resident Evaluation" tool was used for the initial assessment required to be completed "prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier." This tool contained all the required content of the "uniform assessment tool" required by MN Rule 4659.0150.
        2. The "*Nurse Reassessment Visit*" tool was used for every ongoing assessment required (no more than 14 calendar days after initiation of services; as needed based on changes in the resident's needs; and at least every 90 calendar days.) This form ***did not*** contain all the required content of the "uniform assessment tool" required by MN Rule 4659.0150.
    ii. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee. R2's Resident Evaluation, although dated January 16, 2025, was completed on January 16, 2026, based on the current Resident Roster which indicated a "start of services" date on January 16, 2026. The following dates reflect when a *Nurse Reassessment Visit* was completed:
        1. January 29, 2026 (a 14-day assessment)

2. April 16, 2026 (a 90-day assessment)
3. May 14, 2026 (a change in condition post hospitalization assessment)
4. September 4, 2026 (a change in condition post hospitalization assessment); 113 days since the prior completed assessment

iii. R3 was admitted to the licensee on October 1, 2023, with diagnoses that included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. The following dates reflect when a *Nurse Reassessment Visit* was completed:
1. November 17, 2025, (a 90-day assessment)
2. February 15, 2026, (a 90-day assessment)
3. May 7, 2026 (a change in condition post hospitalization assessment)
4. No further assessments were completed by the time of survey on September 22, 2026; 138 days have lapsed.

iv. R4 began receiving services on October 1, 2023, with diagnoses that included acute ischemic stroke and diabetes. The following dates reflect when a *Nurse Reassessment Visit* was completed:
1. October 16, 2025 (a 90-day assessment)
2. January 15, 2026 (a 90-day assessment)
3. April 20, 2026 (a 90-day assessment)
4. No further assessments were completed by the time of survey on September 22, 2026; 155 days have lapsed.

v. The Uniform Assessment tool must include (but is not limited to) the following elements:
1. Physical health status, including: a review of relevant health history and current health conditions, including medical and nursing diagnoses...
2. Infectious conditions
3. Pain, including location; frequency; intensity; duration; and effectiveness of medication and nonmedication alternatives
4. Skin conditions
5. List of treatments, including type, frequency, and level of assistance needed

vi. On September 23, 2026, at 9:40 a.m., LALD/CNS-A stated he completed wound assessments with weekly measurements on R2. R2's record included “Weekly Nursing Skin Reviews” from January 16, 2026, through September 19, 2026, that were completed weekly by LALD/CNS-A. The document included multiple areas to be circled or filled in to indicate a description of the wound, including drainage, signs of infection, and progress of the wound. The assessment pieces were left predominantly incomplete. Additionally, the document did not include measurements of the wound.

d. Minn. Stat. § **144G.71, Subd. 5**, an assisted living facility (licensed nurse, licensed health professional, or authorized prescriber) must complete medication

reconciliation if they are providing medication management services to a resident when the licensee did not complete a medication reconciliation for a resident upon return from the hospital.

i. On July 20, 2026, during a homecare nurse visit for wound care, R2 rated his wound-site pain level a “8” on a scale of one to ten.
ii. On August 19, 2026, during a homecare nurse visit for wound care, R2 rated his wound-site pain level a “10” on a scale of one to ten.
iii. On August 28, 2026, during a homecare nurse visit for wound care, R2 rated his wound-site pain level a “10” on a scale of one to ten.
iv. R2 was hospitalized from September 1 to 4, 2026, for right leg wounds with infection requiring surgery. R2's hospital After Visit Summary (AVS) dated September 4, 2026, included a new order for oxycodone immediate release (IR) 5 milligrams (mg) tablet take one tablet by mouth every six hours as needed for severe pain. The AVS also included orders to continue these medications: Atarax 25 mg, take one tablet every six hours as needed for itching; and Afrin Nasal Spray 0.05%, use 1 spray each nostril as needed for congestion.
v. R2’s September 2026 medication administration record (MAR) ***did not*** include Oxycodone, Atarax, or Afrin.
vi. On September 14, 2026, during a homecare nurse visit for wound care, R2 rated his wound-site pain level a “10” on a scale of one to ten.
vii. R2 saw his primary care provider on September 22, 2026. The AVS directed R2 to begin taking Celebrex 200 mg, take one capsule two times daily (for pain), and reiterated the Oxycodone order from September 4, 2026.
viii. On September 24, 2026, at 8:25 a.m., LALD/CNS-A stated he was unaware the hospital discharge AVS dated September 4, 2026, included an order for oxycodone.
ix. On September 24, 2026, at 9:37 a.m., LALD/CNS-A stated he was unaware the pharmacy had delivered the oxycodone on September 22, 2026, (following the doctor visit) but discovered the oxycodone in with R2's other medications in the evening September 23, 2026.
x. On September 24, 2026, at 9:47 a.m., LALD/CNS-A stated the pharmacy sends the prescription bottles and he uses the prescription bottles to transcribe the order onto the MAR (instead of a physician order). LALD/CNS-A stated he does not reconcile the AVS with the residents' current orders/MAR; he only goes by the prescription bottles, as they are received from the pharmacy.
xi. The licensee's Assessment of Medications policy dated February 7, 2023, included “medication reconciliation” as one of the required elements.

e. Minn. Stat. § **144G. 71, Subd. 7**, the RN must instruct the ULP in the proper method to administer medications when the nurse provided improper methods to the ULP for administering mediations to a resident via gastrostomy tube (G-tube).

i. On September 23, 2026, at 12:05 p.m., ULP-B explained the process used to administer R3's medications earlier that day: ULP-B took three oral tablets from the pill caddy and crushed them all together and dissolved with water (escitalopram 10 mg; senna 8.6 mg; ascorbic acid 500 mg). Then ULP-B measured the liquid medications (pantoprazole 40 mg- give 20 milliliters (ml); baclofen 25 mg/5 ml- give 4 ml; and cholecalciferol 400 unit/ml- give 0.5 ml (200 units)). ULP-B placed them all (crushed and liquid medications) into a measuring cup and pulled medications into a syringe. ULP-B drew up 40 ml of tap water, flushed the gastrostomy tube, then pushed the medications in. Then ULP-B flushed the gastrostomy tube again with another 40 ml of tap water.

ii. LALD/CNS-A was present during the explanation and agreed with the procedure.

iii. Although both ULP-B and LALD/CNS-A stated training and competency checks were completed, ULP-B's employee file did not contain evidence that the RN completed training and competency for medication administration via gastrostomy tube.

iv. On September 24, 2026, at 11:02 a.m., the surveyor telephoned R3's pharmacy. Pharmacist-D and the surveyor reviewed R3's current medications. The surveyor asked if R3's medications can be given together and Pharmacist-D stated, "Typically, I don't advise giving them together, especially the pantoprazole, it should be given separate because it would absorb correctly if given separate."

v. The licensee's undated, Medication Protocol for Gastrostomy Tubes procedure indicated the staff to crush medication(s) in pill crusher or other container as instructed by the RN, draw up 30 ml of water into syringe, flush G-tube, draw up liquified medication into the syringe, instill the medication into the G-tube, draw up another 30 ml and flush the tubing after the medication has been instilled.

f. Minn. Stat. § **144G.72, Subd. 4**, the RN (or authorized licensed health professional) has instructed the ULP, and the ULP has demonstrated the ability to competently follow the procedures of the delegated treatment when the RN did not train, nor check competency for a treatment delivered to a resident.

i. On September 22, 2026, at 12:17 p.m., the surveyor observed ULP-C remove the humidified oxygen tracheostomy mask from R3, provide suctioning through the tracheostomy three times and replace the humidified oxygen tracheostomy mask; the oxygen was set at 6 liters per minute (Lpm) and humidity set at 2%.

ii. On September 23, 2026, at 1:14 p.m., the surveyor observed ULP-B remove the humidified oxygen tracheostomy mask, provide suctioning through the tracheostomy twice and replace the humidified oxygen tracheostomy mask; the oxygen was set at 6 Lpm and humidity set at 2%.

iii. Although both ULP-C and ULP-B stated LALD/CNS-A trained, and competency tested them for tracheostomy suctioning and humidified

oxygen tracheostomy mask, both ULP-C and ULP-B's employee record did not contain evidence that an RN or authorized licensed health professional had instructed the ULPs in the proper methods or had demonstrated ability to competently follow the procedure for administering humidified oxygen via tracheostomy mask.

iv. R3's provider orders dated October 25, 2025, included oxygen concentration at 4 Lpm while in bed to keep oxygen saturation 90% or greater. Oxygen can be off while in chair if oxygen saturation is greater than 92%. Humidifier to tracheostomy should be at 2% and if needed, it can be at 3% for short period of time.

g. Minn. Stat. § **144G. 72, Subd. 5**, treatments administered are in the resident record when the treatments for two residents were not administered as ordered.

i. R3's diagnoses included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage and received assistance with weekly blood glucose, oxygen, vest therapy, tracheostomy humidifier, gastrostomy tube (G-tube), and tracheostomy suctioning.

1. R3's provider orders dated October 25, 2025, included, “oxygen concentration at 4 Lpm while in bed to keep oxygen saturation 90% or greater. Oxygen can be off while in chair if oxygen saturation is greater than 92%”.
2. R3's treatment record for September 2026, included a scheduled service twice daily at 6:00 a.m. and 8:30 p.m. that indicated, "oxygen should be at 4 liters/minutes continuous."
3. On September 22, 2026, at 12:17 p.m., LALD/CNS-A and the surveyor observed R3's oxygen concentrator located in R3's bathroom; it was set at 6 Lpm.
4. On September 23, 2026, at 1:14 p.m., the surveyor again observed R3's oxygen concentrator set at 6 Lpm.
5. On September 24, 2026, at 11:48 a.m., R3's continuous oxygen saturation measured 94% on 6 Lpm humidified oxygen via tracheostomy mask.
6. On September 22, 2026, at 12:17 p.m., LALD/CNS-A stated the order for oxygen changed from 4 Lpm to 6 Lpm after R3’s hospitalization for pneumonia. R3's record did not include discharge hospital orders from that event; there was no current order representing a change in oxygen dosing.
7. On September 23, 2026, at 2:15 p.m., LALD/CNS-A stated he cannot locate discharge paperwork from R3’s hospitalization from April 29, 2026, to May 7, 2026. Therefore, R3's oxygen therapy was not administered as prescribed.

ii. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee; R2’s record contained a blank, undated service

plan. Despite the blank service plan, services such as medication management and wound care were provided.

1. On September 25, 2026, at 9:20 a.m., a homecare nurse (RN-E) stated the current dressing orders were to cleanse with wound cleanser, apply “Saline Activated Aquacell AG” and cover with superabsorbent dressing to all areas completed three times a week and as needed. RN-E further stated she was unaware LALD/CNS-A was completing the dressing-change all other days (the home care agency was not scheduled); the dressing should only be changed if it is saturated or soiled.
2. On September 24, 2026, at 12:35 p.m., LALD/CNS-A stated he changed the dressing based on how he was instructed by the home care nurse; he does not have any orders (to follow) for wound care as the doctor sends those to the home care agency. On September 25, 2026, at 9:45 a.m., LALD/CNS-A further stated he was supposed to change the dressing every day; therefore, on days the home care nurse did not visit, LALD/CNS-A completed the dressing change (four times per week).
3. On September 24, 2026, at 11:20 a.m., RN-E stated she or a co-worker completed wound care three times a week for R2 since he was admitted to the facility in January 2026. During their visits, they completed wound care; during one visit a week, they completed an assessment of each wound with measurements and descriptions. RN-E further stated R2 had the right medial and right lateral ankle wounds since admission and they were chronic. The wound to the right medial ankle had been skin grafted and has shown great improvement. The wound to the lateral ankle had progressively gotten larger. The wound to the top of the foot just started in the last couple weeks and had worsened and grown in size. RN-E confirmed that during one dressing change, maggots fell out of the dressing. RN-E was unsure how that would occur since R2 should have had a dressing covering the entire lower leg and foot at all times.
4. On September 23, 2026, at 9:32 a.m., the surveyor observed LALD/CNS-A complete a dressing change to four wounds on R2's right lower leg. R2's Treatment Administration Record (TAR) dated September 2026, and signed off every day September 4-22, 2026, by LALD/CNS-A, included wound care instructions that did not reflect R2's hospital discharge instructions dated September 4, 2026.

h. Minn. Stat. § **144G.91, Subd.4**, residents have the right to receive care and services based on accepted health care standards when the licensee did not assess two residents’ (R3, R4) with hospital bed rails, and one resident (R-2) with a consumer grab bar.

i. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee; R2's record contained a blank, undated service plan.
    1. On September 22, 2026, at 1:16 p.m., the surveyor observed R2's consumer grab bars; R2 had a traditional bed with a U-shaped grab bar on the right side of the bed against the wall and another multi-section rounded rectangular grab bar on the left side of the bed. The grab bar on the left side of the bed had legs that went down towards the floor but were approximately one inch off the floor, two bars that went between the mattress and the box spring, and straps that were wrapped around the bar and locked on the bar. The straps did not secure the device to the bed. The grab bar easily pulled out from the bed leaving a gap that could be risk for injury and/or strangulation. LALD/CNS-A stated he was able to move the rail on the right side out; therefore, the U-shaped grab bar was also not secured to the bed.
    2. R2's Side-Rail Use Assessment Form dated January 16, 2025, indicated R2 requested side-rails be raised while in bed, and R2 used the side rails for positioning and support. The assessment did not address proper installation of the consumer grab bars or that the Consumer Product Safety Commission (CPSC) website was checked for recalls.
    3. On September 22, 2026, at 1:16 p.m., LALD/CNS-A stated the facility did not have manufacturer's instructions for the grab bars. R2 was admitted to the facility with the grab bars on his personal bed. LALD/CNS-A stated he was unaware of the requirement to have the manufacturer instructions; was unaware of the responsibility of the licensee to ensure the grab bars were installed per manufacturer guidelines; and was unaware he had to check for recalls on the CPSC website, therefore the CPSC had not been checked for recalls.

ii. R3's diagnoses included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage and received assistance with weekly blood glucose, oxygen, vest therapy, tracheostomy humidifier, gastrostomy tube (G-tube), and tracheostomy suctioning.
    1. On September 22, 2026, at 2:32 p.m., the surveyor observed R3 laying in his hospital bed with bilateral full bedrails in the up position.
    2. R3's Side-Rail Use Assessment Form was completed last on October 1, 2023.

iii. R4's diagnosis included acute ischemic stroke and received assistance with dressing, grooming, bathing, incontinence cares, medication management, blood sugar checks, and stand-by assist.

1. On September 22, 2026, at 2:32 p.m., the surveyor observed R4's hospital bed which had bilateral upper half rails in the up position.
2. R4's Side-Rail Use Assessment Form was completed last on October 1, 2023.

iv. On September 22, 2026, at 2:20 p.m., LALD/CNS-A stated side rail assessments were only completed upon admission.

[These violations are elaborated in the attached state form, enclosure 1.]

5. Based on these findings, MDH determined that the violations occurred and pose an imminent risk of harm to the health and safety of residents.
   a. When a nurse delegates tasks to unlicensed personnel that require clinical reasoning, nursing judgment, or critical decision making, the nurse places the resident (patient) at imminent risk of harm and jeopardizes their safety. The Minnesota Nurse Practice Act dictates a licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making (to unlicensed caregivers). Doing so poses an imminent risk of harm to the resident's health and safety.
   b. Despite the facility's own policies indicating they will staff based on the residents' assessed needs, the facility did not provide required staffing levels during the twelve-hour night shifts ensuring safe and appropriate cares could be provided for their residents. Improper staffing disallowed the facility to provide safe, competent, required services to meet the health and safety needs of the residents.
   c. A timely, comprehensive nursing assessment is a thorough and complete evaluation of a resident (patient) used to establish a baseline, identify new or changing health issues, and guide safe, appropriate cares. A thorough, head-to-toe nursing assessment is the first step in the nursing process. Failure to do this jeopardizes the resident's health and safety.
   d. Failing to conduct a reconciliation of a resident's medication orders poses an imminent risk of harm to the resident's health and safety; reconciliations are used to identify medication discrepancies and prevent medication errors, which can be fatal.
   e. When administering two or more medications, each medication should be administered separately with a flush between medications of 15 to 30 ml of water. Not following this standard practice of nursing or administering medications via G-tube per physician's/pharmacist's orders poses an imminent risk of harm to the resident's health and safety.
   f. Not following physicians' orders for the proper route and amount of oxygen delivered to a resident poses an imminent risk of harm to the resident's health and safety.
   g. The facility must document the reason why a wound treatment was not administered (as prescribed) and any follow-up procedures that were provided

to meet the resident's needs. Failure to correct errors in treatment administration poses an imminent risk of harm to the resident's health and safety.

h. The need for bed rails must be assessed on a frequent, regular basis. At a minimum, this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition. The Uniform Assessment Tool requirement in MN Rules 4659.0150 includes the requirement to assess "mobility, including ambulation, transfers, and assistive devices". Both consumer and hospital bedrails are considered assistive devices. Failure to conduct routine bedrail assessments poses an imminent risk of harm to the resident's health and safety.

6. The foregoing violations constitute grounds to revoke a license under Minn. Stat. § 144G.20, Subd. 1(a) (1), (3), and (14).

Temporary Suspension and Requirement for Transition Plan

This letter notifies you that MDH is immediately temporarily suspending the assisted living facility license number 425883 for ninety (90) days, thereby prohibiting you from operating the assisted living facility.

1. Minn. Stat. § 144G.20, Subd. 12(a) states:

"Within five business days after proceedings are initiated by the commissioner to revoke or suspend a facility's license, or a decision by the commissioner not to renew a living facility's license, the controlling individual of the facility or a designee must provide to the commissioner, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities the names of residents and the names and addresses of the residents' designated representatives and legal representatives, and family or other contacts listed in the assisted living contract."

2. Minn. Stat. § 144G.20, Subd. 15 states:

"(a) The process of suspending, revoking, or refusing to renew a license must include a plan for transferring affected residents' cares to other providers by the facility. The commissioner shall monitor the transfer plan. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension, the licensee shall provide the commissioner, the lead agencies as defined in section 256B.0911, county adult protection and case managers, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities with the following information:

1) a list of all residents, including full names and all contact information on file;

2) a list of the resident's legal representatives and designated representatives and family or other contacts listed in the assisted living contract, including full names and all contact information on file;

3) the location or current residence of each resident;

4) the payer sources for each resident, including payer source identification numbers; and

5) for each resident, a copy of the resident's service plan and a list of the types

of services being provided.

(b) The revocation, refusal to renew, or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The licensee shall cooperate with the commissioner and the lead agencies, county adult protection and case managers, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities during the process of transferring care of residents to qualified providers. Within three calendar days of being notified of the final revocation, refusal to renew, or suspension action, the facility must notify and disclose to each of the residents, or the resident's legal and designated representatives or emergency contact persons, that the commissioner is taking action against the facility's license by providing a copy of the revocation, refusal to renew, or suspension notice issued by the commissioner. If the facility does not comply with the disclosure requirements in this section, the commissioner shall notify the residents, legal and designated representatives, or emergency contact persons about the actions being taken. Lead agencies, county adult protection and case managers, and the Office of Ombudsman for Long-Term Care may also provide this information. The revocation, refusal to renew, or suspension notice is public data except for any private data contained therein."

The temporary suspension is in effect immediately, however you are required to ensure residents receive necessary care until they are safely transferred to other facilities. Once all residents are transferred, you must not provide assisted living services to anyone as long as the temporary suspension is in effect. Pursuant to Minn. Stat. § 144G.10, Subd. 4, operating an assisted living facility without a license is a misdemeanor.

Expedited Hearing Regarding Immediate Temporary Suspension

Pursuant to Minn. Stat. § 144G.20, Subd. 17(a):

"Within five business days of receipt of the licensee's timely appeal of a temporary suspension or issuance of a conditional license, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten business days before the hearing. Certified mail to the last known address is sufficient. The scope of the hearing shall be limited solely to the issue of whether the temporary suspension or issuance of a conditional license should remain in effect and whether there is sufficient evidence to conclude that the licensee's actions or failure to comply with applicable laws are Level 3 or Level 4 violations as defined in section 144G.31, or that there were violations that posed an imminent risk of harm to the resident's health and safety."

1. You may appeal the temporary suspension. Pursuant to Minn. Stat. 144G.20 Subd. 3(c), the appeal must be made in writing by certified mail or personal service. If mailed, the

appeal must be postmarked and sent to MDH within five calendar days after you receive this order. The appeal can be sent to the following address:

The appeal can be submitted online to the HRD Appeals Submission Form
https://forms.web.health.state.mn.us/form/HRDAppealsForm

or mailed to the following address:

Reconsideration Unit, Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
625 Robert Street North
Saint Paul, MN 55155

2. If an appeal is made by personal service, it must be received by MDH within five calendar days after you receive this order and be served to:

   Minnesota Department of Health
   Attn: General Counsel's Office
   Freeman Office Building
   625 Robert Street North
   Saint Paul, MN 55155

3. If a timely appeal is received, MDH is required by Minn. Stat. § 144G.20, Subd. 17(a) to request assignment of an Administrative Law Judge within five business days of receipt of the appeal. A hearing must be conducted within 30 calendar days of the request for assignment of an Administrative Law Judge, and the Commissioner must issue notice of the hearing at least ten business days before the hearing. The scope of the hearing will be limited to whether the temporary suspension should remain in effect and whether there is sufficient evidence to conclude there were violations that posed an imminent risk of harm to the resident's health and safety.

4. Under Minn. Stat. 144G.20 Subd. 17(b), the Administrative Law Judge will issue findings of fact, conclusions, and a recommendation within ten business days from the date of hearing. The parties will then have ten calendar days to submit exceptions to the Administrative Law Judge's report. The record must close at the end of the ten-day period for submission of exceptions. The Commissioner's final order will be issued within ten business days from the close of the record. If the final order affirms an immediate suspension, the licensee is prohibited from operation pending a final order on any appeal of the revocation issued below.
5. Under Minn. Stat. 144G.20 Subd. 17(b), if an appeal of a temporary immediate suspension is withdrawn or dismissed, the Commissioner will issue a final order affirming the temporary immediate suspension within ten calendar days of MDH's receipt of that dismissal or withdrawal.

Revocation and Appeal of the Revocation

This letter also notifies you that MDH is revoking the assisted living facility license number 425883.

1. **Relationship to the Immediate Temporary Suspension:** Pursuant to Minn. Stat. § 144G.20, Subd. 17(c), if the final order from the expedited hearing process (described above) affirms the immediate temporary suspension, and a final sanction is issued under Minn. Stat. § 144G.20, Subds. 1 and 2, "the licensee is prohibited from operation pending a final commissioner's order after the contested case hearing conducted under chapter 14." Therefore, if the immediate temporary suspension issued above is upheld by the Commissioner of Health, you are prohibited from providing assisted living services unless and until the facility successfully appeals this Notice of Revocation and the Commissioner issues a final order reversing this Notice of Revocation.

2. **Impact on issuance of other licenses:** Minn. Stat. § 144G.20, Subd. 5 states that if a Minnesota assisted living facility license is "revoked because of noncompliance with applicable laws or rules," then the owner and managerial officials of that assisted living facility "shall not be eligible to apply for nor will be granted an assisted living facility license under this chapter or a home care provider license under chapter 144A, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, for five years following the effective date of the nonrenewal or revocation. If the owners or managerial officials already have enrollment status, the Department of Human Services shall terminate that enrollment."

3. You may appeal this decision.
   a. Minn. Stat. § 144G.20, Subd. 13 states you are entitled to a contested case hearing under Minn. Stat. § 14.57 to 14.69.
   b. Minn. Stat. § 144G.20, Subd. 18 states to appeal "an action against a license under this section, a licensee must request a hearing no later than 15 business days after the licensee receives notice of the action."
   c. You may appeal the revocation, whether or not you also appeal the temporary suspension.

4. The appeal must be made in writing by mail or delivered to MDH, per Minn. Stat. § 144G.20, Subd. 14, and must contain "a brief and plain statement describing every matter or issue contested" and "a brief and plain statement of any new matter that the applicant or assisted living facility believes constitutes a defense or mitigating factor." The appeal can be sent to the following address:

   Reconsideration Unit, Health Regulation Division
   Minnesota Department of Health
   P.O. Box 64900
   625 Robert Street North
   Saint Paul, MN 55155

5. Minn. Stat. § 144G.20, Subd. 16 states “Within 15 business days of receipt of the licensee's timely appeal of a sanction under this section, other than for a temporary suspension, the commissioner shall request assignment of an administrative law judge. The commissioner's request must include a proposed date, time, and place of hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 90 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause or for purposes of discussing settlement. In no case shall one or more extensions be granted for a total of more than 90 calendar days unless there is a criminal action pending against the licensee.”
6. If you do not request a hearing within 15 business days of your receipt of this notice, or if an appeal of the revocation is withdrawn or dismissed, this Notice will become the Commissioner’s order of revocation.

Issuance of Survey Results / No Limited Authority:

MDH will continue to conduct any surveys or investigations already initiated and may issue correction orders to High Drive as well as maltreatment determinations under Minn. Stat. § 626.557. Based on the results of those findings, or on the results of any additional complaint investigations which may be initiated, or on the results of any other inspection conducted by MDH or another agency with appropriate jurisdiction, MDH may employ any of the enforcement tools listed in Minn. Stat. § 144G.20. This Order does not in any way or manner limit or affect the authority of MDH to proceed against the facility or any employee of the facility, based on any act, conduct or admission that justifies that action, whether it occurred before or after the date of this Order.

Carol Backstrom
Assistant Commissioner
MINNESOTA DEPARTMENT OF HEALTH
HEALTH SYSTEMS BUREAU

Carol Backstrom

October 12, 2026
Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	09/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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: SL39715016-0 On September 21, 2026, through September 25, 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 three residents; three receiving services under the Assisted Living Facility license. 0450: An immediate correction order was issued on September 22, 2026, at a level 3/Isolated (G). The licensee took immediate action; however, the scope and level remain at G. 0470: An immediate correction order was issued on September 22, 2026, at a level 3/Pattern (H). The licensee took immediate action; however, the scope and level remain at H. 1620: An immediate correction order was issued	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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.	

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0 000	Continued From page 1 on September 25, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I. 1730: An immediate correction order was issued on September 24, 2026, at a level 4/Widespread (L). The licensee took immediate action; however, the scope and level remain at L. 1750: An immediate correction order was issued on September 24, 2026, at a level 4/Widespread (L). 1950: An immediate correction order was issued on September 24, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I. 1960: An immediate correction order was issued on September 25, 2026, at a level 4/Isolated (K). The licensee took immediate action; however, the scope and level remain at K. 2310: An immediate correction order was issued on September 22, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I.	0 000		
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction	0 345		

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0 345	Continued From page 2 order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make available the most recent plan of correction (POC) in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders issued for the licensee's survey completed June 12, 2024. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). On July 16, 2024, the licensee was provided with the results of their survey along with form 2567 (a form on which citations are documented with findings of the survey). On September 21, 2026, at 1:12 p.m., the surveyor verbally requested licensed assisted	0 345		

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0 345	Continued From page 3 living director/clinical nurse supervisor (LALD/CNS)-A provide a copy of the licensee's documented POC related to the previous survey. On September 23, 2026, at 9:12 a.m., LALD/CNS-A stated the plan of correction could not be found and knows it was completed as it was reviewed at a follow up survey. No further information provided.	0 345		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 420		

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0 420	Continued From page 4 portion or all of the residents). The findings include: The licensee had an assisted living license effective June 16, 2026. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and belief, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on April 17, 2026. As a result of this survey, the following orders were issued under 0345, 0450, 0470, 0480, 0650, 0660, 0680, 0730, 0790, 0800, 0810, 0910, 1440, 1470, 1500, 1620, 1640, 1730, 1750, 1760, 1880, 1890, 1910, 1940, 1950, 1960, 1970, and 2310,	0 420		

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0 420	Continued From page 5 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to promote a safe and therapeutic environment when the clinical nurse supervisor (CNS) delegated activities that required clinical reasoning, nursing judgment, or critical decision making to unlicensed personnel (ULP) for one of one resident (R3) with a tracheostomy (a surgical opening in a person's neck into the trachea (windpipe) to help the person breathe).	0 450		

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0 450	Continued From page 6 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 15, 2026, indicated the licensee provided tracheostomy suctioning assistance. The UDALSA also indicated the licensee did not have a licensed nurse onsite 24/7. On September 21, 2025, at approximately 1:12 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee had one resident (R3) with a tracheostomy. R3 was admitted to the licensee on October 1, 2023, with diagnoses that included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. R3's service plan dated February 5, 2025, indicated R2 received services to include tracheostomy care; however, the service plan did not include tracheostomy suctioning. On September 22, 2025, at 12:17 p.m., the surveyor observed ULP-C gather suctioning equipment at R3's bedside. ULP-C washed hands, donned sterile gloves, suction catheter, and inserted suction catheter into R3's tracheostomy and suction three times with	0 450		

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0 450	Continued From page 7 distilled water rinse in between suctioning. The surveyor asked ULP-C if the registered nurse (RN) trained and competency tested for tracheostomy suctioning and ULP-C stated the RN did. However, ULP-C's employee file did not include a competency test. On September 22, 2026, at 1:22 p.m., LALD/CNS-A stated being unaware that suctioning a tracheostomy could not be delegated to a ULP. MN Statutes 148.171, Subd. 7a. "Delegation" means the transfer of authority to another nurse or competent, unlicensed assistive person to perform a specific nursing task or activity in a specific situation. MN Statutes 148.171, Subd. 24. "Unlicensed assistive personnel" means any unlicensed person to whom nursing tasks or activities may be delegated or assigned, as approved by the board. The National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, indicated the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Nurse Practice Act grounds for disciplinary action: (8) Delegating or accepting the delegation of a nursing function or a prescribed health care function when the delegation or acceptance could reasonably be expected to result in unsafe or ineffective patient care. (17) Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the	0 450		

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0 450	Continued From page 8 unlawful practice of advanced practice, professional, or practical nursing. MN Statute 148.171, Subd.15 "Practice of Professional Nursing" means the performance of those services that incorporates caring for all patients in all settings through nursing standards recognized by the board and includes, but not limited to: (1) providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish a health status baseline and plan of care, and address changes in a patient's condition; (7) providing safe and effective nursing care; (8) promoting a safe and therapeutic environment; (9) advocating for the best interests of individual patients; (10) evaluating responses to interventions and the effectiveness of the plan of care; (17) accountability for the quality of care delivered No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took action to mitigate risk; however, the scope and level remain at G. The correction order was minimally edited since delivery of the immediate order of correction.	0 450		
0 470 SS=H	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	0 470		

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0 470	Continued From page 9 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they always had sufficient staffing 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 for two of two residents (R2, R3) who required two-person transfers with a mechanical lift. This resulted in an immediate correction order on September 22, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 470		

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0 470	Continued From page 10 or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: On September 22, 2026, the surveyor entered the licensee at 6:40 a.m. and unlicensed personnel (ULP)-B was mopping the floor. ULP-B stated she was the only one scheduled for her shift, and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A arrived around 6:00 a.m. R2 R2 was admitted to the licensee for assisted living services on January 16, 2026. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee. R2's record included a blank and undated service plan. R2's change condition assessment dated May 14, 2026, indicated R2 was wheelchair bound and needed daily assist of two for easy stand for transfers (type of mechanical lift, a device designed to assist caregivers in safely transferring patients or individuals with limited mobility). R3	0 470		

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0 470	Continued From page 11 R3 was admitted to the licensee for assisted living services on October 1, 2023. R3's diagnoses included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. R3's service plan dated July 20, 2024, indicated R3 received assistance with dressing, grooming, incontinence, catheter care, mobility assistance, two person transfer, safety checks, weekly blood glucose, oxygen, vest therapy, tracheostomy humidifier, gastrostomy tube (G-tube), medication administration, tracheostomy suctioning, housekeeping, and laundry. R3's change of condition assessment dated May 7, 2026, indicated R3 was wheelchair and bed bound and needed daily assist of two for Hoyer lift transfers (type of mechanical lift, a device designed to assist caregivers in safely transferring patients or individuals with the inability to stand). The licensee lacked a current staffing plan. The Facility Weekly schedule dated September 20, 2026, to September 26, 2026, indicated staffing requirements for each shift Sunday through Saturday: day shift 7:00 a.m. - 7:00 p.m., two unlicensed staff required, and night shift 7:00 p.m. - 7:00 a.m., one staff required. The licensee's posted staff schedule dated September 20, 2026, through September 26, 2026, indicated two staff were available for morning shift and one staff was available for night shift. On September 22, 2026, at 1:20 p.m., the	0 470		

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	39715	A. BUILDING: _____ B. WING _____	09/25/2026

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0 470	Continued From page 12 surveyor inquired how R3 was transferred at night and in case of an emergency. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff would call the "on-call staff" (ULP-F) who lived "about five miles away." Google maps show, depending on which route is used, ULP-F lives anywhere from 27 to 29 miles from the facility. Minnesota Administrative Rule 4659.0180, Subp. 5, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." The manufacturer's instructions for Invacare Get Up Lift dated February 5, 2018, indicated "Invacare recommends that two assistants be used for all lifting preparation and transferring to/from procedures; however, the stand up lift can be operated with one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case." The manufacturer's instructions for Span F500P Hoyer lift (full body lift) dated 2019, indicated two or more are required for transfers. Although the licensee asserted to the surveyor they had policies on a mechanical lift transfer, the licensee was unable to locate or produce the policies for the surveyor to review at the time the immediate order for correction was issued on September 22, 2026, at 2:16 p.m. No further information was provided.	0 470		

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0 470	Continued From page 13 TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remains at H. STAFFING PLAN In addition, the licensee failed to develop and implement a staffing plan that included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility, and failed to have a daily work schedule posted in a central location, in accordance with Minnesota Administrative Rule 4659.0180, accessible to staff, residents, volunteers, and the public as required. On September 21, 2026, at 2:08 p.m., the surveyor observed a staffing schedule posted in the common area dated for June 2026. The licensee did not have a current staff schedule posted. The licensee lacked a staffing plan with documentation of an evaluation at least twice a year of the appropriateness of staffing levels in the facility. On September 21, 2026, at 2:33 p.m., LALD/CNS-A stated they had not reviewed the staffing plan twice yearly and the posted staff schedule was outdated.	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 14 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 15 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 22, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 16 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included documentation of training and competency testing for two of two employees (unlicensed personnel (ULP)-C, ULP-B). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 17 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on October 1, 2023, and provided direct care to the facility's residents. On September 22, 2026, at 12:17 p.m., the surveyor observed ULP-C provide R3's tracheostomy suctioning. On September 22, 2026, at 7:50 a.m., ULP-C stated she was trained and competency tested by the registered nurse (RN) for all cares and treatments. ULP-C's record lacked evidence of training and competency testing for the following: - Ankle-foot Orthoses (AFO) - BiPAP/CPAP to Trach, Mask and Nose Pillow - Changing Tracheostomy Ties - Condom Catheter: Application and Removal - Cough Assistance - Gastrostomy Tube Feedings - G/J Tube Site Care - Gastrostomy Tube Venting - Gastrostomy Tube Water Flush - Obstructed Trach Protocol BIBS: Bag, Irrigate, Bag, Suction - Pulmonary Vest - Tracheostomy Stoma Skin Care - Tracheostomy Cuff Inflation/Deflation	0 650		

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0 650	Continued From page 18 ULP-B ULP-B was hired on June 4, 2025, and provided direct care to the facility's residents. On September 23, 2026, at 1:14 p.m., the surveyor observed ULP-B provide R3's tracheostomy suctioning. On September 23, 2026, at 12:26 p.m., ULP-B stated the nurse trained and observed her completing all of the procedures the first week of training, which included the pulmonary vest, tracheostomy cares, and gastrostomy cares, feeding and water boluses. ULP-B's record lacked evidence of training and competency testing for the following: - Ankle-foot Orthoses (AFO) - BiPAP/CPAP to Trach, Mask and Nose Pillow - Changing Tracheostomy Ties - Condom Catheter: Application and Removal - Cough Assistance - Gastrostomy Tube Feedings - G/J Tube Site Care - Gastrostomy Tube Venting - Gastrostomy Tube Water Flush - Obstructed Trach Protocol BIBS: Bag, Irrigate, Bag, Suction - Pulmonary Vest - Tracheostomy Stoma Skin Care - Tracheostomy Cuff Inflation/Deflation On September 23, 2026, at 3:41 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all staff were trained on the procedures in the binder, but he did not complete any documentation of the training and competency testing.	0 650		

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0 650	Continued From page 19 The licensee's procedure binder contained the following procedures: - Ankle-foot Orthoses (AFO) - BiPAP/CPAP to Trach, Mask and Nose Pillow - Changing Tracheostomy Ties - Condom Catheter: Application and Removal - Cough Assistance - Gastrostomy Tube Feedings - G/J Tube Site Care - Gastrostomy Tube Venting - Gastrostomy Tube Water Flush - Obstructed Trach Protocol BIBS: Bag, Irrigate, Bag, Suction - Pulmonary Vest - Tracheostomy Stoma Skin Care - Tracheostomy Cuff Inflation/Deflation No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.	0 660		

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0 660	Continued From page 20 (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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a two-step TST (tuberculin skin test) or other TB screening such as a blood test or chest x-ray, upon hire, for two of two employees (unlicensed personnel (ULP)-C, (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on October 1, 2023, and provided direct care to the facility's residents. On September 22, 2026, at 11:44 a.m., the surveyor observed ULP-C administer R4's morning medication and testing R4's blood glucose. ULP-C employee record contained a Consent and Release for TB Screening signed September 25, 2023, which included the TB symptom	0 660		

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0 660	Continued From page 21 screening information. ULP-C's record lacked evidence of TB testing by a 2-step TST or a blood test. ULP-B ULP-B was hired on June 4, 2025, and provided direct care to the facility's residents. On September 23, 2026, at 1:14 p.m., the surveyor observed ULP-B provide R3's tracheostomy suctioning. ULP-B's employee record contained a Consent and Release for TB Screening signed February 10, 2025, which included the TB symptom screening information; however, TB symptom screening information was obtained approximately four months prior to being hired. ULP-B's record included a single step completed on June 19, 2025; however, lacked evidence of TB testing by a 2-step TST or a blood test. On September 24, 2026, at 12:53 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C's file should have contained a copy of symptom screening and 2-step TST. LALD/CNS-A stated he only completed single step TSTs for all employees and was unaware of the requirement for a second step. The licensee's Tuberculosis Screening/Prevention dated February 7, 2023, included: "1. Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis. 2. Baseline screening includes an assessment for TB history and current TB symptoms.	0 660		

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0 660	Continued From page 22 3. An employee's history of BCG vaccination will be disregarded when administering and interpreting TST results. 4. The baseline test may be either TST (2-step) or BAMT. 5. If the first-step TST is negative, the second-step TST will be administered 1--3 weeks after the first TST result was read." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 23 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 had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated October 1, 2023, lacked the following required content: - establish and maintain a comprehensive EP, reviewed/updated annually; - documentation of coordination with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documentation of missing resident plan reviewed quarterly; - provide EP training at least annually; - maintain documentation of EP training; - exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; On September 24, 2026, at 3:48 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was still working on updating their EPP to be compliant	0 680		

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0 680	Continued From page 24 with state requirements. LALD/CNS-A stated it was missing the components listed above. The licensee's Emergency Preparedness policy dated February 7, 2023, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. 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=D	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	0 730		

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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
0 730	Continued From page 25 documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of a written discharge summary for one of one resident (R1).	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	09/25/2026

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0 730	Continued From page 26 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 October 1, 2023, and discharged on July 29, 2025. R1's diagnosis included chronic atrial fibrillation. R1's file lacked a discharge summary to include: - a summary of the resident's stay that includes course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; - a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and - post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medication and non-medical services the resident will need.	0 730		

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0 730	Continued From page 27 On September 21, 2026, at 3:52 p.m., assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's discharge summary was missing the required content as listed above. LALD/CNS-A stated a "nurse-to-nurse" was completed via telephone and did not document the medication. LALD/CNS-A stated he gave R1 the medications to bring to the new assisted living. The licensee's Clinical Record policy dated February 7, 2023, indicated the resident record would contain a discharge summary, including service termination notice and related documentation when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790		

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0 790	Continued From page 28 Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled Physical Environment Inspection Report (PEIR) dated September 22, 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=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 30 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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	0 810		

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0 810	Continued From page 31 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for all three residents (R2, R3, R4) residing in the facility.	0 910		

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0 910	Continued From page 32 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Assisted Living Contract was signed by R2 on January 16, 2026. R3's Assisted Living Contract was signed by R3 on October 2, 2023. R4's Assisted Living Contract was signed by R4 on October 1, 2023. R2, R3, and R4's Assisted Living Contract lacked a written contract to include the provider's health facility identification (HFID) number for the facility. On September 24, 2026, at 12:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the contract did not include the HFID number for any of the residents' contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

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01440	Continued From page 33 therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP)-B) was supervised by a registered nurse (RN) within 30 days after providing delegated tasks. 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).	01440		

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01440	Continued From page 34 The findings include: ULP-B was hired on June 4, 2025, and provided direct care to the facility's residents. On September 23, 2026, at 1:14 p.m., the surveyor observed ULP-B provide R3's tracheostomy suctioning. ULP's employee record included a 30-day RN supervision form dated June 11, 2025, with an incorrect hire date of June 11, 2026. In addition, ULP-B's employee included ULP-B's record included Home Health Aide skills competency evaluation by LALD/CNS-A on June 20, 2025. ULP-B's record lacked evidence of direct supervision within 30 days after first performing a delegated task. On September 24, 2026, at 3:48 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B's 30-day supervision was not completed within 30 days after first performing a delegated task. The licensee's Supervision: Unlicensed Staff policy dated February 7, 2023, included direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21)	01440		

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01470	Continued From page 35	01470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or 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	01470		

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01470	Continued From page 36 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 one of one employee (unlicensed personnel (ULP)-B) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01470		

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01470	Continued From page 37 The findings include: ULP-B was hired on June 4, 2025, and provided direct care to the facility's residents. On September 23, 2026, at 1:14 p.m., the surveyor observed ULP-B provide R3's tracheostomy suctioning. ULP-B's employee record did not include proof of completing the following required orientation content: -overview of Assisted Living statutes; -review of provider's policies and procedures; -handing of resident complaints, reporting of complaints, where to report; and -consumer advocacy services On September 24, 2026, at 3:48 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B had not completed all the required assisted living orientation as it was missed. The licensee's Staff Orientation and Education policy dated February 7, 2023, indicated orientation topics will include, but not be limited to, the following: -overview of Assisted Living statutes; -review of provider's policies and procedures; -handing of resident complaints, reporting of complaints, where to report; and -consumer advocacy services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		

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01500	Continued From page 38	01500		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 39 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on October 1, 2023, and	01500		

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	39715	A. BUILDING: _____ B. WING _____	09/25/2026

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01500	Continued From page 40 provided direct care to the facility's residents. On September 22, 2026, at 11:44 a.m., the surveyor observed ULP-C administer R4's morning medication and test R4's blood glucose. ULP-C's employee record indicated ULP-C had received dementia, mental health, and person centered care training on May 14, 2026; However, the record lacked evidence ULP-C had completed the following annual training topics as required: - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Infection control techniques; and - Review of provider's policies and procedures On September 24, 2026, at 12:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was unaware ULP-C's employee record did not include all of the required annual trainings. The licensee's Staff Orientation and Education policy dated February 7, 2023, included: "12. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 13. Education topics will include, but not be limited to, the following: - Reporting of maltreatment of adults - Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights - Review of the organization's policies and procedures related to provision of assisted living services and how to implement them - Infection control techniques used in the home - Implementation of infection control standards	01500		

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01500	Continued From page 41 based on current recommendations per the CDC - Hand washing techniques - Need for/use of personal protective equipment (PPE), including: 1. Gloves 2. Gowns 3. Masks - Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades - Disinfection of reusable equipment - Disinfection of environmental surfaces - Reporting of communicable diseases" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered	01620		

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01620	Continued From page 42 planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a comprehensive wound assessment on a routine basis for the licensee's one resident with wounds (R2), and failed to complete ongoing assessments timely and using the uniform	01620		

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01620	Continued From page 43 assessment tool for three of three residents (R2, R3, R4) in accordance with MN Rules 4659.0150, Subp. 2. 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: R2 WOUND ASSESSMENTS R2 began receiving services on January 16, 2026. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee. On September 23, 2026, at 9:32 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A complete a dressing change to four wounds on R2's right lower leg. LALD/CNS-A removed the ace wrap and old dressings. LALD/CNS-A then cleaned all four areas with wound cleanser and gauze. He cut Qwick Dressing with Aquaconductive Technology to fit two of the wounds, one on the medial right calf below a healed area and one on the the medial right foot. Approximately 1/3 of the top of the right foot was open and weeping fluid, the open areas extended down between the great toe and second toe. LALD/CNS-A opened Xeroform Petrolatum	01620		

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01620	Continued From page 44 dressing and cut it to fit over the area and then placed Zetuvit Plus superabsorbant dressing over the Xeroform. LALD/CNS-A opened and cut another Xeroform Petrolatum dressing and opened it to fit over the very large wound on the lateral portion of the right calf and then placed Zetuvit Plus superabsorbant dressing over the Xeroform. LALD/CNS-A then wrapped the entire lower leg in gauze roll bandage and an ace wrap. During the procedure, R2 stated he had been hospitalized in the last couple months because when the nurse removed the dressing, maggots fell out, "there had to be 60 or more of them". Therefore, he was in the hospital for "awhile." R2 also stated that he knew eventually that leg was going to "kill him," but he wasn't "going to let them cut it off like they did with the left leg." During the procedure, LALD/CNS-A stated R2 previously had skin grafts to the medial ankle wound and that had healed except for the area below it, the open area to the foot was new and was increasing in size. The lateral portion of the right calf was a chronic wound and had increased "some" in size. LALD/CNS-A further stated the wounds were all chronic wounds. On September 23, 2026, at 9:40 a.m., LALD/CNS-A stated he completed wound assessments with measurements weekly. R2's record included Weekly Nursing Skin Reviews from January 16, 2026, through September 19, 2026, that were completed weekly by LALD/CNS-A. However, the document had multiple areas that were to be circled or filled in to indicate a description of the wound, including: drainage, signs of infection, and progress of the wound, but nothing was circled or documented for those assessment pieces. Additionally, the document did not include measurements of the	01620		

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01620	Continued From page 45 wound. The documentation included: "Treatment - wound cleansed per facility protocol - daily dressing changes continue as ordered due to drainage and intermittent bleeding - Dressing type: 4 x 5 Aquacell AG, 5 x 7 abdominal pads, secondary dressing (79 Mextra), 4 inch roll gauze, Spandagrip size F. - Resident tolerated procedure well." Additionally, there were typed notes with explanations of the wounds, but there were four wounds that included the same information, even though the wounds all had different appearances and depth. R2's Treatment Record dated September 2026, and signed off every day September 4-22, 2026, by LALD/CNS-A, included: "1. Prepare: Wash hands thoroughly and put on clean gloves Gather supplies: saline/cleanser, gauze, prescribed dressing, barrier cream, tape/bandage, trash bag. Position the patient comfortably with good lighting 2. Remove Old Dressing. Gently loosen and remove dressing If stuck, moisten with saline-don't pull forcefully. Observe and note: Amount and color of drainage Odor Condition of the old dressing Dispose and remove gloves - wash hands - put on new gloves. 3. Assess the wound look for: Size, depth, and edges Tissue color (red,pink, yellow slough, black eschar) Drainage amount and type Signs of infection: increasing redness,warmth, swelling, pus, foul odor, fever, increased pain 4. Clean the Wound: Use normal saline or wound cleanser (not hydrogen peroxide or iodine unless specifically ordered) Irrigate gently from clean to dirty (center outward) Pat surrounding skin dry" 5. Protect: Surrounding Skin Apply barrier cream	01620		

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01620	Continued From page 46 or skin prep to prevent maceration present 6. Apply New Dressing (per wound type/order) Examples: Moist wounds with drainage: foam, alginate, hydro fiber Dry wounds: hydrogel+cover dressing Shallow wounds: non-adherent gauze + secondary dressing Place dressing without stretching the skin. Secure with tape, wrap or bandage wrap, or bandage. 7. Finish Dispose of supplies safely remove gloves and wash hands R2's hospital discharge instructions dated September 4, 2026, indicated the reason for hospitalization was right leg wounds with infection requiring surgery and antibiotics. On September 24, 2026, at 11:20 a.m., R2's home care nurse (RN)-E stated her or a co-worker completed wound care three times a week for R2 since he was admitted to the facility in January 2026. During their visit, they completed wound care, and during one visit a week, they would complete an assessment of each wound with measurements and descriptions. RN-E further stated R2 had the right medial and right lateral ankle wounds since admission and they were chronic. The wound to the right medial ankle had been skin grafted and has shown great improvement. The wound to the lateral ankle had progressively gotten larger. The wound to the top of the foot just started in the last couple weeks and had worsened and grown in size. RN-E confirmed a co-worker was doing a dressing change and maggots fell out of the dressing. RN-E stated being unsure how that would occur since R2 should have had a dressing	01620		

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01620	Continued From page 47 covering the entire lower leg and foot at all times. On September 25, 2026, at 9:45 a.m., LALD/CNS-A stated he fills out the Weekly Nursing Skin Review and thought that was good enough since the home care does their assessment with measurements and documents it. The licensee's Care Coordination policy dated February 7, 2023, included: "1. The RN or Licensed Health Professional is responsible for ensuring coordination* with the resident's primary care provider as well as all medical providers and case managers involved in the resident's plan of care. 2. Orders from all prescribers involved in the plan of care will be integrated to assure coordination of services and interventions provided to the resident. 3. Care coordination will involve the resident, resident's legal representative, resident's designated representative, family members, case manager and caregiver(s) as appropriate. 4. Services are integrated to assure that all resident needs and factors affecting resident safety and treatment effectiveness are coordinated among all health care providers serving the resident. 5. When indicated, a care conference may be convened to assure that services are coordinated and meeting the needs/goals of the resident. Minutes of case conferences will be documented in the clinical record establishing that effective interchange, reporting and coordination of resident care does occur. 6. When there are changes in the resident's needs or status, including financial needs, High Drive Customized/Assisted Living will work with the resident, resident representative(s) and/or	01620		

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01620	Continued From page 48 case manager to assure that the resident receives safe and appropriate care until: a. The resident is transferred to another provider/setting b. The services of High Drive Customized/Assisted Living are adjusted to meet the changing needs of the resident c. Another plan is developed and implemented with the care team, including the resident/responsible party 7. If a resident is transferred, discharged or admitted to an inpatient facility**, High Drive Customized/Assisted Living will take steps to ensure a coordinated transfer or discharge. 8. Activities of care coordination will be documented in the clinical record." ONGOING ASSESSMENTS R2 R2's record included the following assessments: - Resident Evaluation (initial assessment) was completed January 16, 2025 [sic]; - Nurse Reassessment Visit dated January 29, 2026, indicated it was a 14-day assessment; - Nurse Reassessment Visit dated April 16, 2026, indicated it was a 90 day assessment; - Nurse Reassessment Visit dated May 14, 2026, indicated it was a hospital return assessment; - Nurse Reassessment Visit dated September 4, 2026, indicated it was a hospital return assessment, this was 113 days after the previous assessment, thus exceeding 90 calendar days. The reassessment tool used for the 14-day and ongoing reassessments did not include all of the required content of a uniform assessment as according to MN Rules 4659.0150, Subp. 2. R3	01620		

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01620	Continued From page 49 R3 was admitted to the licensee on October 1, 2023, with diagnoses that included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. On September 22, 2025, at 12:17 p.m., the surveyor observed ULP-C provide tracheostomy suctioning. R3's record included the following assessments: - Nurse Reassessment Visit dated November 17, 2025, indicated it was a 90-day assessment; - Nurse Reassessment Visit dated February 15, 2026, indicated it was a 90-day assessment; - Nurse Reassessment Visit dated May 7, 2026, indicated it was a hospital return assessment; - Nurse reassessment was next due on or before August 5, 2026; however, LALD/CNS-A stated he did not complete an assessment, thus exceeding 90 calendar days. The reassessment tool used for ongoing reassessments did not include all of the required content of a uniform assessment as according to MN Rules 4659.0150, Subp. 2. R4 R4 began receiving services on October 1, 2023, with diagnoses that included acute ischemic stroke and diabetes. On September 22, 2026, at 11:45 a.m., the surveyor observed ULP-C administer R4's morning medications. R4's record included the following assessments: - Nurse Reassessment Visit dated October 16, 2025, indicated it was a 90-day assessment; - Nurse Reassessment Visit dated January 15, 2026, indicated it was a 90-day assessment;	01620		

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01620	Continued From page 50 - Nurse Reassessment Visit dated April 20, 2026, indicated it was a 90-day assessment; - Nurse reassessment was next due on or before July 19, 2026; however, LALD/CNS-A stated he did not complete an assessment, thus exceeding 90 calendar days. The reassessment tool used for ongoing reassessments did not include all of the required content of a uniform assessment as according to MN Rules 4659.0150, Subp. 2. On September 25, 2026, at 9:45 a.m., LALD/CNS-A stated he was unaware the Nurse Reassessment Visit form did not include all the required content of the uniform assessment tool, and he only completes the Resident Evaluation form on admission. The 14 day, 90 day and significant change assessments were all completed using the Nurse Reassessment Visit form. Further, LALD/CNS-A was unaware some assessments were not completed within the 90 days. The licensee's Assessment and Reassessment policy dated February 7, 2023, indicated an individualized initial evaluation of all new residents receiving assisted living services will be completed by a registered nurse in order to develop a personalized service plan. The assessment shall be revised regularly and as appropriate. The RN will provide the admission comprehensive assessment. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took immediate action to mitigate risk; however, the scope and level remains at l.	01620		

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01620	Continued From page 51 The correction order was minimally edited since delivery of the immediate order of correction.	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan was developed and signed within 14 days for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 52 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 began receiving services on January 16, 2026. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and a left above the knee amputation. On September 23, 2026, at 9:32 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A complete a dressing change to four wounds on R2's right lower leg. R2's record lacked evidence a signed service plan had been completed. On September 23, 2026, at 8:50 a.m. LALD/CNS-A stated he could not find a signed service plan for R2; therefore, he had completed one on September 22, 2026, after the surveyor had requested it. LALD/CNS-A further stated R2 should have had one completed. The licensee's Service Plan policy dated February 7, 2023, included: "1. Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an	01640		

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HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

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01640	Continued From page 53 agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. 2. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. 3. The service plan must be revised, if needed, based on resident review or reassessment. 4. The initial service plan and any revisions are signed by a representative from [licensee] and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=L	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;	01730		

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01730	Continued From page 54 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a medication reconciliation after a hospital return for one of one resident (R2). This resulted in an immediate correction order identified on September 24, 2026. This practice resulted in a level four violation (a violation that harmed a resident ' s health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or	01730		

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01730	Continued From page 55 death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2026, at 9:32 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A changing dressings to multiple wounds on R2's right lower leg/foot. On September 23, 2026, at 9:32 a.m. during the dressing change, R2 complained of chronic back pain and right leg pain. R2's hospital return After Visit Summary (AVS) dated September 4, 2026, included a new order for oxycodone immediate release (IR) 5 milligrams (mg) tablet take one tablet by mouth every six hours as needed for severe pain. R2's unsigned, AVS dated September 22, 2026, included: - new order for celecoxib (pain) 200 mg by mouth two times daily - oxycodone IR 5 mg tablet take one tablet by mouth every six hours as needed for severe pain. R2's medication administration record (MAR) dated September 1-23, 2026, did not include oxycodone or celecoxib. On September 24, 2026, at 8:25 a.m., LALD/CNS-A stated he brought R2 to the doctor on September 22, 2026, and at that time, the doctor ordered oxycodone. LALD/CNS-A was unaware the hospital discharge AVS dated September 4, 2026, included an order for	01730		

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01730	Continued From page 56 oxycodone. On September 24, 2026, at 9:37 a.m., LALD/CNS-A stated he had discovered the oxycodone in with R2's other medications in the evening September 23, 2026, and was unaware the pharmacy had delivered the oxycodone on September 22, 2026, (following the doctor visit). LALD/CNS-A went to the pharmacy on September 24, 2026, to pick up a signed copy of the oxycodone prescription. On September 24, 2026, at 9:47 a.m., LALD/CNS-A stated the pharmacy sends the prescription bottles and he uses the prescription bottles to document the order onto the MAR. LALD/CNS-A stated he does not reconcile the AVS with the residents' current orders/MAR, he only goes by the prescription bottles, as they are received from the pharmacy. On September 24, 2026, at 10:04 a.m., R2 stated he has had back pain for 23 years since he broke his back rating it at "10" on a scale of 1-10. Additionally, R2 has right lower leg pain with the wounds at a "10." R2 further stated the leg pain is off and on, but the pain is worse during dressing changes. The licensee's Assessment of Medications policy dated February 7, 2023, included: "1. The RN will provide and document a face-to-face assessment with the resident. 2. The assessment includes the following elements. a. Identification of all medications, including over-the-counter and herbal/dietary supplements b. Medication reconciliation i. Identification of the most accurate list of all medications the resident is taking, including the	01730		

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01730	Continued From page 57 name, dosage, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber of other provider ii. Assessment of the following: 1. Indication for medications 2. Effectiveness of drug therapy 3. Side effects 4. Immediate desired effects 5. Unusual and unexpected effects 6. Actual or potential drug interactions 7. Duplicate drug therapy 8. Non-adherence with drug therapy 9. Drug therapy currently associated with laboratory monitoring 10. Allergic reactions 11. Changes in condition that contraindicate continued administration of the medication 12. Any difficulties with taking the medication 13. Resident preferences in how to take medications" No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took immediate action to mitigate risk; however, the scope and level remains at L. The correction order was minimally edited since delivery of the immediate order of correction. MEDICATION PLAN CONTENT In addition, the licensee failed to ensure all required content was included in the medication plan for R2.	01730		

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01730	Continued From page 58 R2's Resident Evaluation dated as completed January 16, 2025 [sic], indicated R2 received medication set up and and administration of medications. R2's record did not include the following required content: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - 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 24, 2026, at 9:37 a.m. LALD/CNS-A stated he was unaware R2's record was missing the required content in the medication plan. The licensee's Service Plan for Medication Management policy dated February 7, 2023, included: "1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the resident assessment* and addressing i. Resident preference ii. Risk of diversion	01730		

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01730	Continued From page 59 iii. Instructions per manufacturer c. Documentation procedures d. Procedures for medication reconciliation* e. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely f. Description of medication management tasks to be delegated to unlicensed personnel g. Plans for staff notifying the licensed health professional when/if a problem with medication management services arises h. Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions."	01730		
01750 SS=L	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse instructed unlicensed personnel	01750		

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01750	Continued From page 60 (ULP)-B) in the accepted method of practice to administer medications for one of one resident (R3), with a gastrostomy tube (G-tube) and the ULP had failed to demonstrate the ability to competently follow the procedures for administering medications. This resulted in an immediate correction order on September 24, 2026. This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired June 10, 2025, to provide direct care services to the licensee's residents. On September 23, 2026, at 12:05 p.m., the surveyor asked ULP-B the procedure for administering medications via gastrostomy tube. ULP-B verbalized/demonstrated the ULP would take three oral tablets from the pill caddy and crush all together and dissolve with water: escitalopram 10 milligrams (mg); senna 8.6 mg; ascorbic acid 500 mg; along with liquid medication: pantoprazole 40 mg- give 20 milliliter (ml); baclofen 25 mg/5 ml- give 4 ml; and cholecalciferol 400 unit/ml- give 0.5 ml (200 unit) into a measuring cup and pulled medications into a syringe. ULP-B would draw up 40 ml of tap water, flush gastrostomy tube, push the medications in, and flush the gastrostomy tube again with another 40 ml of tap water. Licensed	01750		

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01750	Continued From page 61 assisted living director/clinical nurse supervisor (LALD/CNS)-A was present during the demonstration and agreed with the procedure. On September 23, 2026, at 12:26 p.m., ULP-B and LALD/CNS-A stated LALD/CNS-A trained and competency tested ULP-B the first week of working with the licensee. ULP-B's employee file lacked evidence the RN completed training and competency for medication administration via gastrostomy tube. On September 24, 2026, at 11:02 a.m., the surveyor telephoned R3's pharmacy. Pharmacist-D and the surveyor reviewed R3's current medications. The surveyor asked if R3's medications can be given together and Pharmacist-D stated, "Typically, I don't advise giving them together, especially the pantoprazole, it should be given separate because it would absorb correctly if given separate." The licensee's undated, Medication Protocol for Gastrostomy Tubes procedure indicated the staff to crush medication(s) in pill crusher or other container as instructed by the RN, draw up 30 ml of water into syringe, flush G-tube, draw up liquified medication into the syringe, instill the medication into the G-tube, draw up another 30 ml and flush the tubing after the medication has been instilled. The licensee's Medication Administration policy dated February 7, 2023, indicated that when the registered nurse delegates tasks to unlicensed personnel, that person will ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures.	01750		

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01750	Continued From page 62 According to Fundamentals of Nursing textbook dated 2025, "Administering Medications through a Feeding Tube," it indicates if administering two or more medications, give each medication separately and flush between medications with 15 to 30 ml of water." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The correction order was minimally edited since delivery of immediate order of correction.	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of one resident (R2).	01760		

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01760	Continued From page 63 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 began receiving services on January 16, 2026. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and left above the knee amputation. On September 23, 2026, at 9:32 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A complete a dressing change to four wounds on R2's right lower leg. R2's Resident Evaluation (initial assessment) documented as completed January 16, 2025 [sic], indicted R2 received medication administration. R2's record lacked evidence a signed service plan had been completed. R2's signed hospital discharge After Visit Summary dated September 4, 2026, included - start oxycodone immediate release (narcotic pain medications) 5 milligram (mg) tablet by mouth every six hours as needed for severe pain; - Whey protein powder (wound healing) 64 mg by	01760		

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01760	Continued From page 64 mouth two times a day; - Afrin nasal spray one spray in nostril as needed for congestion; and - hydroxyzine 25 mg one tablet every six hours as needed for itching R2's medication administration record (MAR) dated September 2026, did not include the oxycodone, Whey protein powder, Afrin Nasal spray, or hydroxyzine. R2's record lacked documentation the Whey powder was being administered. On September 24, 2026, at 9:47 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated when he gets medications from the pharmacy, he uses the prescription bottle to transcribe them onto the MAR. LALD/CNS-A further stated being unaware of the discrepancies between the signed physician orders and the MAR, and LALD/CNS-A did not reconcile the post hospitalization AVS, or obtain clarifications with changes of medications received from the pharmacy. The licensee's Medication Administration policy dated February 7, 2023, indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber. The licensee's Medication Orders policy dated February 7, 2026, included: - "[Licensee] will administer medications as prescribed by the authorized prescriber" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01880 SS=F	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 ensure medications were securely locked permitting only authorized personnel to have access. This had the potential to affect all residents within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2026, at 10:36 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A removed the medication cabinet keys from another cabinet in the kitchen near the medication cabinet. LALD/CNS-A opened the cabinet for the surveyor to review. On September 25, 2026, 12:48 p.m., LALD/CNS-A stated being unaware the keys to the medication cabinet could not be located in a cabinet accessible to other staff, residents, and visitors.	01880		

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01880	Continued From page 66 The licensee's Storage/Control of Medications policy dated February 7, 2023, included "Medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with open and/or expiration dates in the facility's medication cupboard and failed to ensure the medications were stored with a full prescription label or labeled with the resident's name for all three of the licensee's residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01890		

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HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

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01890	Continued From page 67 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 22, 2026, at 12:17 p.m., the surveyor and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed the facility's medication cabinet and observed the following: - R4 had Omega Pure EPA- DHA 600+ Omega 3 Plus Vitamin E supplement, Nutridyn Multi Powder Vitamin, and a Probiotic and Mineral container. None of these items were labeled with R4's name or other identifying information. - R3 had one unopened and one opened Systane ointment which were not labeled with R3's name or other identifying information. - R2 had Beets CoQ10 gummies, Aller-Aid, Delsym cough syrup which were located on a different shelf than the one labeled R2's name. LALD/CNS-A stated they belonged to R2 and moved them to R2's shelf. The items did not have R2's name or any other identifying information on it. On September 22, 2026, at 12:17 p.m., LALD/CNS-A stated these were over the counter supplements and medications, so they did not have a pharmacy label. LALD/CNS-A was unaware that they need to be somehow labeled with the resident name or other identifier to assure they were used for that resident. On September 23, 2026, at 10:36 a.m., LALD/CNS-A stated R4's eye drops were stored in R4's room. The surveyor observed the bottle of travoprost with LALD/CNS-A and the pharmacy label was worn, with most of it torn off and the remaining label was illegible. LALD/CNS-A stated	01890		

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01890	Continued From page 68 it should have a pharmacy label, but it tore off. The licensee's Storage/Control of Medications policy dated February 7, 2023, included: "10. Prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container(s) in which they were dispensed by the pharmacy bearing the original prescription label with legible information. 11. The medication is labeled completely and legibly. The medication label should contain the following. a. Prescription number and name of medication b. Strength and quantity c. Expiration date for time-dated drugs d. Directions for use e. Resident's name f. Prescriber's name g. Date issued h. Name and address of licensed pharmacy issuing the medication" " Over-the-counter (OTC) medications and dietary supplements that are not prescribed should be retained in their original, labeled container with directions for use." "If a sample medication is used, the same package will be labeled with the resident's name and kept with the resident's other medications. The registered nurse is responsible for assuring that there are no contraindications for the medication." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications	01910		

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01910	Continued From page 69 (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete in the resident's record the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01910		

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01910	Continued From page 70 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 October 1, 2023, with diagnosis including chronic atrial fibrillation. R1's discharge summary dated July 29, 2025, identified R1 received services which included medication administration. R1's Medication Administration Record (MAR) dated July 2025, included: -Eliquis 5 milligrams (mg), by mouth twice daily; -carvedilol 6.25 mg, by mouth twice daily; -Oyster shell calcium with vitamin D 500 mg-200 international units (IU), by mouth twice daily; -lisinopril 20 mg, 2 tablets by mouth daily; -methyl B-12 5000 micrograms (mcg), by mouth daily; -furosemide 20 mg, by mouth daily; -donepezil 5 mg, by mouth at bedtime; and -latanoprost 0.005 %, instill one drop in both eyes at bedtime R1 was discharged from the licensee on July 29, 2025. R1's record lacked documentation of a disposition of medications upon discharge that included: -medication name; -strength; -prescription number as applicable -quantity; -to whom the medications were given; -date of disposition; and -names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 71 On September 21, 2026, at 3:52 p.m., assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee did not complete a disposition of medications upon R1's discharge. LALD/CNS-A stated that it was missing. The licensee's Disposition and Disposal of Medication policy dated February 7, 2023, indicated upon disposition, the facility will document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, method of disposition or to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	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	01940		

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01940	Continued From page 72 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 ensure an individual treatment management plan was developed for two of three residents (R2, R3) receiving a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2	01940		

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01940	Continued From page 73 R2 began receiving services on January 16, 2026. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and a left above the knee amputation. On September 23, 2026, at 9:32 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A complete a dressing change to four wounds on R2's right lower leg. R2's record lacked evidence a signed service plan or a treatment plan to had been completed with the required content. R2's Treatment Record dated September 2026, and signed off every day September 4-22, 2026, by LALD/CNS-A, included: "1. Prepare: Wash hands thoroughly and put on clean gloves Gather supplies: saline/cleanser, gauze, prescribed dressing, barrier cream, tape/bandage, trash bag. Position the patient comfortably with good lighting 2. Remove Old Dressing. Gently loosen and remove dressing If stuck, moisten with saline-don't pull forcefully. Observe and note: Amount and color of drainage Odor Condition of the old dressing Dispose and remove gloves - wash hands - put on new gloves. 3. Assess the wound look for: Size, depth, and edges Tissue color (red,pink, yellow slough, black eschar) Drainage amount and type Signs of infection: increasing redness,warmth, swelling, pus, foul odor, fever, increased pain 4. Clean the Wound: Use normal saline or wound cleanser (not hydrogen peroxide or iodine unless specifically ordered) Irrigate gently from clean to	01940		

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01940	Continued From page 74 dirty (center outward) Pat surrounding skin dry" 5. Protect: Surrounding Skin Apply barrier cream or skin prep to prevent maceration present 6. Apply New Dressing (per wound type/order) Examples: Moist wounds with drainage: foam, alginate, hydro fiber Dry wounds: hydrogel+cover dressing Shallow wounds: non-adherent gauze + secondary dressing Place dressing without stretching the skin. Secure with tape, wrap or bandage wrap, or bandage. 7. Finish Dispose of supplies safely remove gloves and wash hands" R2's physician order dated September 10, 2026, (received from the home health agency) indicated right lower extremity wound care instructions; 1. Cleanse with wound cleanser and pat dry with gauze. 2. Apply saline activated Aquacel ag to wound bed ensuring 1 cm overlay onto surrounding tissue. 3. Cover with superabsorbant dressing, wrap with Kerlix and secure with medical tape. 4. Dressing is to be changed 3 x weekly by home care nurse, and as needed if dressing becomes soiled or falls off by caregiver. On September 25, 2026, at 9:20 a.m., hospice registered nurse (RN)-E stated the current dressing orders were to cleanse with wound cleanser, apply Aquacell AG and superabsorbant to all areas completed three times a week and as needed. RN-E further stated she was unaware LALD/CNS-A was completing the dressing change all other days the home care agency were not scheduled, and it should only be changed if it is saturated or soiled.	01940		

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01940	Continued From page 75 On September 25, 2026, at 12:48 p.m. LALD/CNS-A stated R2's record included a blank service plan in R2's chart; therefore, he had completed it on September 22, 2026, after the surveyor had requested it. LALD/CNS-A further stated R2 should have had one completed. R3 R3 was admitted to the licensee on October 1, 2023, with diagnoses that included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. On September 22, 2025, at 12:17 p.m., the surveyor observed unlicensed personnel (ULP)-C provide tracheostomy suctioning. R3's service plan indicated R3 received services to include blood glucose monitoring, chest percussion therapy (CPT), oxygen management, tracheostomy humidity, gastrostomy tube (g-tube), tracheostomy suctioning, and condom catheter. R3's provider's orders dated October 30, 2025, included an order for blood glucose monitoring weekly, CPT twice daily, oxygen monitoring at 4 liters per minute continuous, to keep oxygen saturation 90% or greater, tracheostomy humidity at 2 % continuous, g-tube Jevity 1.5 formula, 65 milliliters per hour continuous; flush 250 milliliters every three hours via g-tube pump, tracheostomy suctioning suction twice daily and as needed, condom catheter change daily and as needed, urine bag change twice monthly. R3's unsigned and undated, Treatment Plan included tracheostomy tube suctioning daily 2-3 times and as needed, vest therapy daily, oxygen	01940		

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01940	Continued From page 76 at 4 liters via humidified tracheostomy mask continuous, tracheostomy humidity 4-5 % via tracheostomy mask continuous. R3's record lacked a treatment management plan to include the following required content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of all treatment or therapy tasks that will be delegated to unlicensed personnel; and - 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. On September 25, 2026, at 12:48 p.m., LALD/CNS-A stated R3 was missing the components listed above. The licensee's Treatment and Therapy Management policy dated February 7, 2023, included "The Registered Nurse or licensed health professional is responsible for assessing and developing the treatment and/or therapy service plan for residents." The licensee's Care Coordination policy dated February 7, 2023, included: "1. The RN or Licensed Health Professional is responsible for ensuring coordination* with the resident's primary care provider as well as all medical providers and case managers involved in the resident's plan of care. 2. Orders from all prescribers involved in the	01940		

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01940	Continued From page 77 plan of care will be integrated to assure coordination of services and interventions provided to the resident. 3. Care coordination will involve the resident, resident's legal representative, resident's designated representative, family members, case manager and caregiver(s) as appropriate. 4. Services are integrated to assure that all resident needs and factors affecting resident safety and treatment effectiveness are coordinated among all health care providers serving the resident. 5. When indicated, a care conference may be convened to assure that services are coordinated and meeting the needs/goals of the resident. Minutes of case conferences will be documented in the clinical record establishing that effective interchange, reporting and coordination of resident care does occur. 6. When there are changes in the resident's needs or status, including financial needs, (licensee name) will work with the resident, resident representative(s) and/or case manager to assure that the resident receives safe and appropriate care until: a. The resident is transferred to another provider/setting b. The services of (licensee name) are adjusted to meet the changing needs of the resident c. Another plan is developed and implemented with the care team, including the resident/responsible party 7. If a resident is transferred, discharged or admitted to an inpatient facility**, (licensee name) will take steps to ensure a coordinated transfer or discharge. 8. Activities of care coordination will be documented in the clinical record." No further information provided.	01940		

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01940	Continued From page 78 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks of treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform treatments and the ULP demonstrated competency back to the registered nurse (RN) for two of two employees (unlicensed personnel (ULP)-C, ULP-B).	01950		

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01950	Continued From page 79 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: R3 was admitted to the licensee on October 1, 2023, with diagnoses that included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. ULP-C ULP-C was hired on October 1, 2023, to perform direct care services to the licensee's residents. ULP-B ULP-B was hired on June 10, 2025, to perform direct care services to the licensee's residents. ULP-C and ULP-B's employee record lacked evidence that a registered nurse or authorized licensed health professional had instructed the ULP in the proper methods for each resident and the ULP had demonstrated ability to competently follow the procedure for the following treatment: -humidified oxygen via tracheostomy mask On September 22, 2026, at 12:17 p.m., the surveyor observed ULP-C remove the humidified oxygen tracheostomy mask, provide suctioning through the tracheostomy three times and replace the humidified oxygen tracheostomy mask. ULP-C removed gloves and washed hands. ULP-C stated the clinical nurse supervisor trained, and competency tested for tracheostomy	01950		

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01950	Continued From page 80 suctioning and humidified oxygen tracheostomy mask. The surveyor observed the oxygen to be set at 6 liters per minute (Lpm) and humidity set at 2%. On September 23, 2026, at 1:14 p.m., the surveyor observed ULP-B remove the humidified oxygen tracheostomy mask, provide suctioning through the tracheostomy twice and replace the humidified oxygen tracheostomy mask. ULP-B removed gloves and washed hands. ULP-B stated the clinical nurse supervisor trained, and competency tested ULP-B for tracheostomy suctioning and humidified oxygen tracheostomy mask. The surveyor observed the oxygen to be at 6 Lpm and humidity set at 2%. R3's provider orders dated October 25, 2025, included oxygen concentration at 4 Lpm while in bed to keep oxygen saturation 90% or greater. Oxygen can be off while in chair if oxygen saturation is greater that 92%. Humidifier to tracheostomy should be at 2% and if needed, it can be at 3% for short period of time. R3's services delivered record for September 1 -September 22, 2026, indicated ULP-B completed the following treatment for R3: -humidified oxygen via tracheostomy mask On September 23, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor LALD/CNS-A stated he trains some, but not all staff on the medications and treatments; however, he trained both ULP-B and ULP-C. LALD/CNS-A further stated he does not have a policy or procedure or training materials for humidified oxygen via tracheostomy mask. The licensee's Delegation of Assisted Living	01950		

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01950	Continued From page 81 Tasks policy dated February 7, 2023, indicated that the registered nurse is responsible for appropriately delegating tasks to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remains at I.	01950		
01960 SS=K	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that treatments were completed as ordered for the licensee's two of three residents (R3, R2) who received treatments. This practice resulted in a level four violation (a	01960		

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01960	Continued From page 82 violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: R3 R3 was admitted to the license for assisted living services on October 1, 2023. R3's diagnoses included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. R3's service plan dated July 20, 2024, indicated R3 received assistance with weekly blood glucose, oxygen, vest therapy, tracheostomy humidifier, gastrostomy tube (G-tube), and tracheostomy suctioning. R3's provider orders dated October 25, 2025, included oxygen concentration at 4 Lpm while in bed to keep oxygen saturation 90% or greater. Oxygen can be off while in chair if oxygen saturation is greater that 92%. R3's return from hospital assessment dated May 7, 2026, did not include oxygen management. R3's treatment record for September 2026, included a scheduled service twice daily at 6:00 a.m. and 8:30 p.m. that read "oxygen should be at 4 liters/minutes continuous." On September 22, 2026, at 12:17 p.m.,	01960		

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01960	Continued From page 83 LALD/CNS-A and the surveyor observed R3's oxygen concentrator located in R3's bathroom to be set at 6 liters per minute (Lpm). On September 23, 2026, at 1:14 p.m., the surveyor observed R3's oxygen concentrator located in R3's bathroom to be 6 Lpm. On September 24, 2026, at 11:48 a.m., R3's continuous oxygen saturation measured 94% on 6 Lpm via-humidified oxygen via tracheostomy mask. On September 22, 2026, at 12:17 p.m., LALD/CNS-A stated the order for oxygen changed from 4 Lpm to 6 Lpm after a hospitalization for pneumonia. R3's record did not include discharge hospital orders from that event. On September 23, 2026, at 2:15 p.m., LALD/CNS-A stated he cannot locate R3's hospital discharge paperwork from hospitalization dated April 29, 2026, to May 7, 2026. Therefore, R3's oxygen therapy was not administered as prescribed. According to Biology Insights, "What is Hyperoxia: Causes, Symptoms, and Treatment" dated September 20, 2026, it reads "pulmonary oxygen toxicity develops more slowly, typically over hours to days of breathing high concentrations of oxygen at or near normal atmospheric pressure. The lungs, being the first tissue to encounter inspired oxygen, beat the brunt. Early symptoms include a dry cough, chest tightness, and a burning sensation behind the breastbone. Prolonged exposure leads to inflammation of the airway lining, fluid accumulation, and eventually damage tot he	01960		

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01960	Continued From page 84 delicate gas-exchange surfaces of the lung. The onset and severity depend on both the concentration of oxygen and the duration of exposure." "The primary treatment for hyperoxia is deceptively simple: reduce the amount of oxygen being delivered." "Supplemental oxygen should be treated like any other drug: indicated when needed, titrated to a target, and withdrawn when the target is met." R2 R2 began receiving services on January 16, 2026. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee. On September 23, 2026, at 9:32 a.m., the surveyor observed LALD/CNS-A complete a dressing change to four wounds on R2's right lower leg. LALD/CNS-A removed the ace wrap and old dressings. The medial right calf and foot wounds were dry and LALD/RN-C used wound cleanser to loosen the dressing prior to removal. The top of the foot and the lateral right calf dressings had a moderate amount of drainage but were not saturated. LALD/CNS-A then cleaned all four areas with wound cleanser and gauze. LALD/CNS-A cut Qwick Dressing with Aquaconductive Technology to fit two of the wounds, one on the medial right calf below a healed area and one on the the medial right foot. Approximately 1/3 of the top of the right foot was open and weeping fluid, the open areas extended down between the great toe and second toe. LALD/CNS-A opened Xeroform Petrolatum dressing and cut it to fit over the area and then placed Zetuvit Plus superabsorbant dressing over	01960		

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01960	Continued From page 85 the Xeroform. LALD/CNS-A opened and cut another Xeroform Petrolatum dressing and opened it to fit over the very large wound on the lateral portion of the right calf and then placed Zetuvit Plus superabsorbant dressing over the Xeroform. LALD/CNS-A then wrapped the entire lower leg in gauze roll bandage and an ace wrap. During the procedure, R2 stated he had been hospitalized in the last couple months because when the nurse removed the dressing, maggots fell out, "there had to be 60 or more of them". Therefore, he was in the hospital for "awhile." During the procedure, LALD/CNS-A stated R2 previously had skin grafts to the medial ankle wound and that had healed except for the area below it, the open area to the foot was new and was increasing in size. The lateral portion of the right calf was a chronic wound and had increased "some" in size. LALD/CNS-A further stated the wounds were all chronic wounds. R2's record included Weekly Nursing Skin Reviews from January 16, 2026, through September 19, 2026, that were completed weekly by LALD/CNS-A. However, the document had multiple areas that were to be circled or filled in to indicate a description of the wound, including: drainage, signs of infection, and progress of the wound, but nothing was circled or documented for those assessment pieces. The documentation included: "Treatment - wound cleansed per facility protocol - daily dressing changes continue as ordered due to drainage and intermittent bleeding - Dressing type: 4 x 5 Aquacell AG, 5 x 7 abdominal pads, secondary dressing (79 Mextra), 4 inch roll gauze, Spandagrip size F. - Resident tolerated procedure well."	01960		

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01960	Continued From page 86 R2's Treatment Record dated September 2026, and signed off every day September 4-22, 2026, by LALD/CNS-A, included: "1. Prepare: Wash hands thoroughly and put on clean gloves Gather supplies: saline/cleanser, gauze, prescribed dressing, barrier cream, tape/bandage, trash bag. Position the patient comfortably with good lighting 2. Remove Old Dressing. Gently loosen and remove dressing If stuck, moisten with saline-don't pull forcefully. Observe and note: Amount and color of drainage Odor Condition of the old dressing Dispose and remove gloves - wash hands - put on new gloves. 3. Assess the wound look for: Size, depth, and edges Tissue color (red,pink, yellow slough, black eschar) Drainage amount and type Signs of infection: increasing redness,warmth, swelling, pus, foul odor, fever, increased pain 4. Clean the Wound: Use normal saline or wound cleanser (not hydrogen peroxide or iodine unless specifically ordered) Irrigate gently from clean to dirty (center outward) Pat surrounding skin dry" 5. Protect: Surrounding Skin Apply barrier cream or skin prep to prevent maceration present 6. Apply New Dressing (per wound type/order) Examples: Moist wounds with drainage: foam, alginate, hydro fiber Dry wounds: hydrogel+cover dressing Shallow wounds: non-adherent gauze + secondary dressing Place dressing without stretching the skin. Secure with tape, wrap or bandage wrap, or bandage. 7. Finish Dispose of supplies safely remove gloves and wash hands" R2's hospital discharge instructions dated	01960		

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01960	Continued From page 87 September 4, 2026, indicated the reason for hospitalization was right leg wounds with infection requiring surgery and antibiotics. R2's physician order dated September 10, 2026, (received from the home health agency) indicated right lower extremity wound care instructions; 1. Cleanse with wound cleanser and pat dry with gauze. 2. Apply saline activated Aquacel ag to wound bed ensuring 1 cm overlay onto surrounding tissue. 3. Cover with superabsorbant dressing, wrap with Kerlix and secure with medical tape. 4. Dressing is to be changed 3 x weekly by home care nurse, and as needed if dressing becomes soiled or falls off by caregiver (Assisted Living nurse). On September 24, 2026, at 11:20 a.m., R2's home care nurse (RN)-E stated her or a co-worker completed wound care three times a week for R2 since he was admitted to the facility in January 2026. During their visit, they completed wound care, and during one visit a week, they would complete an assessment of each wound with measurements and descriptions. RN-E further stated R2 had the right medial and right lateral ankle wounds since admission and they were chronic. The wound to the right medial ankle had been skin grafted and has shown great improvement. The wound to the lateral ankle had progressively gotten larger. The wound to the top of the foot just started in the last couple weeks and had worsened and grown in size. RN-E confirmed a co-worker was doing a dressing change and maggots fell out of the dressing. RN-E stated being unsure how that would occur since R2 should have had a dressing covering the entire lower leg and foot at all times.	01960		

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01960	Continued From page 88 On September 24, 2026, at 12:35 p.m., LALD/CNS-A stated he changes the dressing based on how he was instructed by the home care nurse. LALD/CNS-A further stated he does not have any orders for wound care as the doctor sends those to the home care agency. On September 25, 2026, at 9:20 a.m., RN-E stated the current dressing orders were to cleanse with wound cleanser, apply Aquacell AG and superabsorbant to all areas completed three times a week and as needed. RN-E further stated she was unaware LALD/CNS-A was completing the dressing change all other days the home care agency were not scheduled, and it should only be changed if it is saturated or soiled. On September 25, 2026, at 9:45 a.m., LALD/CNS-A stated the home care agency has the wound care orders and he was supposed to change the dressing every day; therefore, on days the home care did not visit, he completed the dressing change. Home Health Care was completing the dressing changes three times a week as ordered by the prescriber. LALD/CNS-A was completing dressing changes every day home care was not there (four times a week). The licensee's Treatment and Therapy Management policy dated February 7, 2023, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain verification that all treatment and therapy was administered as prescribed. According to How Often to Change a Wound	01960		

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01960	Continued From page 89 Dressings A Practical Guide dated January 11, 2026, reads "a wound isn't just a break in the skin; it's a complex microenvironment. Protecting that environment is just as crucial as cleaning it. The right dressing, left in place for the right amount of time, acts as a shield, letting the body do it's remarkable work without constant interruption." The licensee's Care Coordination policy dated February 7, 2023, included: "1. The RN or Licensed Health Professional is responsible for ensuring coordination* with the resident's primary care provider as well as all medical providers and case managers involved in the resident's plan of care. 2. Orders from all prescribers involved in the plan of care will be integrated to assure coordination of services and interventions provided to the resident. 3. Care coordination will involve the resident, resident's legal representative, resident's designated representative, family members, case manager and caregiver(s) as appropriate. 4. Services are integrated to assure that all resident needs and factors affecting resident safety and treatment effectiveness are coordinated among all health care providers serving the resident. 5. When indicated, a care conference may be convened to assure that services are coordinated and meeting the needs/goals of the resident. Minutes of case conferences will be documented in the clinical record establishing that effective interchange, reporting and coordination of resident care does occur. 6. When there are changes in the resident's needs or status, including financial needs, (licensee name) will work with the resident, resident representative(s) and/or case manager	01960		

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01960	Continued From page 90 to assure that the resident receives safe and appropriate care until: a. The resident is transferred to another provider/setting b. The services of (licensee name) are adjusted to meet the changing needs of the resident c. Another plan is developed and implemented with the care team, including the resident/responsible party 7. If a resident is transferred, discharged or admitted to an inpatient facility**, (licensee name) will take steps to ensure a coordinated transfer or discharge. 8. Activities of care coordination will be documented in the clinical record." No further information provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remains at K. The correction order was minimally edited since delivery of the immediate order of correction.	01960		
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	01970		

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01970	Continued From page 91 by: Based on observation, interview, and record review, the licensee failed to ensure they had treatment orders for one of two residents (R2) receiving a treatment. 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 began receiving services on January 16, 2026. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee. On September 23, 2026, at 9:32 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A complete a dressing change to four wounds on R2's right lower leg. R2's record included the following assessments: - Resident Evaluation (initial assessment) was completed January 16, 2026; - Nurse Reassessment Visit dated January 29, 2026, indicated it was a 14-day assessment; - Nurse Reassessment Visit dated April 16, 2026, indicated it was a 90 day assessment; - Nurse Reassessment Visit dated May 14, 2026,	01970		

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01970	Continued From page 92 indicated it was a hospital return assessment; - Nurse Reassessment Visit dated September 4, 2026, indicated it was a hospital return assessment, this was 113 days after the previous assessment, thus exceeding 90 calendar days. R2's record lacked evidence a signed service plan to include a treatment plan, with the required content, had been completed. R2's record included a Treatment Plan form that was not filled in with the required content. R2's record lacked a signed physician order for R2's wound care. R2's record included Weekly Nursing Skin Reviews from January 16, 2026, through September 19, 2026, that were completed weekly by LALD/CNS-A. However, the document had multiple areas that were to be circled or filled in to indicate a description of the wound, including: drainage, signs of infection, and progress of the wound, but nothing was circled or documented for those assessment pieces. Additionally, the document did not include measurements of the wounds. The documentation included: "Treatment - wound cleansed per facility protocol - daily dressing changes continue as ordered due to drainage and intermittent bleeding - Dressing type: 4 x 5 Aquacell AG, 5 x 7 abdominal pads, secondary dressing (79 Mextra), 4 inch roll gauze, Spandagrip size F. - Resident tolerated procedure well." R2's Treatment Record dated September 2026, and signed off every day September 4-22, 2026, by LALD/CNS-A, included: "1. Prepare: Wash hands thoroughly and put on	01970		

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HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

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01970	Continued From page 93 clean gloves Gather supplies: saline/cleanser, gauze, prescribed dressing, barrier cream, tape/bandage, trash bag. Position the patient comfortably with good lighting 2. Remove Old Dressing. Gently loosen and remove dressing If stuck, moisten with saline-don't pull forcefully. Observe and note: Amount and color of drainage Odor Condition of the old dressing Dispose and remove gloves - wash hands - put on new gloves. 3. Assess the wound look for: Size, depth, and edges Tissue color (red, pink, yellow slough, black eschar) Drainage amount and type Signs of infection: increasing redness,warmth, swelling, pus, foul odor, fever, increased pain 4. Clean the Wound: Use normal saline or wound cleanser (not hydrogen peroxide or iodine unless specifically ordered) Irrigate gently from clean to dirty (center outward) Pat surrounding skin dry" 5. Protect: Surrounding Skin Apply barrier cream or skin prep to prevent maceration present 6. Apply New Dressing (per wound type/order) Examples: Moist wounds with drainage: foam, alginate, hydro fiber Dry wounds: hydrogel+cover dressing Shallow wounds: non-adherent gauze + secondary dressing Place dressing without stretching the skin. Secure with tape, wrap or bandage wrap, or bandage. 7. Finish Dispose of supplies safely remove gloves and wash hands" R2's physician order dated September 10, 2026, (requested by the surveyor and received from the home health agency) indicated right lower extremity wound care instructions; 1. Cleanse with wound cleanser and pat dry with gauze.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	09/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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 94 2. Apply saline activated Aquacel ag to wound bed ensuring 1 cm overlay onto surrounding tissue. 3. Cover with superabsorbant dressing, wrap with Kerlix and secure with medical tape. 4. Dressing is to be changed 3 x weekly by home care nurse, and as needed if dressing becomes soiled or falls off by caregiver. On September 24, 2026, at 12:35 p.m., LALD/CNS-A stated he changes the dressing based on how he was instructed by the home care nurse. LALD/CNS-A further stated he does not have any orders for wound care as the doctor sends those to the home care agency. LALD/CNS-A stated he signs off every day because on days the home care does the dressing change, he is "checking the dressing." On September 25, 2026, at 9:20 a.m., hospice registered nurse (RN)-E stated the current dressing orders were to cleanse with wound cleanser, apply Aquacell AG and superabsorbant to all areas completed three times a week and as needed. RN-E further stated she was unaware LALD/CNS-A was completing the dressing change all other days the home care agency were not scheduled, and it should only be changed if it is saturated or soiled. On September 25, 2026, at 9:45 a.m., LALD/CNS-A stated the home care agency has the wound care orders and he was supposed to change the dressing every day; therefore, on days the home care did not visit, he completed the dressing change. The licensee's Treatment and Therapy Management policy dated February 7, 2023, included: "2. The RN or licensed health	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39715	A. BUILDING: _____ B. WING _____	09/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

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01970	Continued From page 95 professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. Resident Name b. Description of the treatment or therapy to be provided c. Frequency d. Other pertinent information" The licensee's Care Coordination policy dated February 7, 2023, included: "1. The RN or Licensed Health Professional is responsible for ensuring coordination* with the resident's primary care provider as well as all medical providers and case managers involved in the resident's plan of care. 2. Orders from all prescribers involved in the plan of care will be integrated to assure coordination of services and interventions provided to the resident. 3. Care coordination will involve the resident, resident's legal representative, resident's designated representative, family members, case manager and caregiver(s) as appropriate. 4. Services are integrated to assure that all resident needs and factors affecting resident safety and treatment effectiveness are coordinated among all health care providers serving the resident. 5. When indicated, a care conference may be convened to assure that services are coordinated and meeting the needs/goals of the resident. Minutes of case conferences will be documented in the clinical record establishing that effective interchange, reporting and coordination of resident care does occur. 6. When there are changes in the resident's needs or status, including financial needs, [licensee name] will work with the resident, resident representative(s) and/or case manager	01970		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH DRIVE CUSTOMIZED ASSISTED LIVING I	13813 HIGH DRIVE BURNSVILLE, MN 55337

(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 96 to assure that the resident receives safe and appropriate care until: a. The resident is transferred to another provider/setting b. The services of [licensee name] are adjusted to meet the changing needs of the resident c. Another plan is developed and implemented with the care team, including the resident/responsible party 7. If a resident is transferred, discharged or admitted to an inpatient facility**, [licensee name] will take steps to ensure a coordinated transfer or discharge. 8. Activities of care coordination will be documented in the clinical record." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for the licensee's one resident (R2) with consumer grab bars and failed to assess the licensee's two residents (R3, R4) with hospital bed rails. This resulted in an	02310		

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	39715	A. BUILDING: _____ B. WING _____	09/25/2026

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02310	Continued From page 97 immediate order issued on September 22, 2026. 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: R2 R2 was admitted and began receiving services on January 16, 2026. R2's diagnoses included hypertension, chronic atrial fibrillation, non-pressure chronic ulcer of right foot with fat layer exposed, and above the left knee amputee. On September 22, 2026, at 1:16 p.m., the surveyor observed R2's consumer grab bars with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. R2 had a traditional bed with a U-shaped grab bar on the right side of the bed against the wall and another multi-section rounded rectangular grab bar on the left side of the bed. The grab bar on the left side of the bed had legs that went down towards the floor but were approximately one inch off the floor, two bars that went between the mattress and the box spring, and straps that were wrapped around the bar and locked on the bar. The straps did not secure the device to the bed. The grab bar easily pulled out from the bed leaving a gap that could be risk for injury and/or strangulation. LALD/CNS-A stated he was able to move the rail on the right side out; therefore, the U-shaped	02310		

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02310	Continued From page 98 grab bar was also not secured to the bed. R2's Side-Rail Use Assessment Form dated January 16, 2025, indicated R2 had requested to have siderails raised while in bed, and R2 used the side rails for positioning and support. The assessment did not address proper installation of the consumer grab bars or that the Consumer Product Safety Commission (CPSC) website had been checked for recalls. On September 22, 2026, at 1:16 p.m., LALD/CNS-A stated the facility did not have manufacturer's instructions for the grab bars. R2 was admitted to the facility with the grab bars on his personal bed. LALD/CNS-A stated he was unaware of the requirement to have the manufacturer instructions and was unaware of the responsibility of the licensee to ensure the grab bars were installed per manufacturer guidelines. LALD/CNS-A further stated being unaware he had to check for recalls on the CPSC website; therefore the CPSC had not been checked for recalls. R3 R3 was admitted and began receiving services on October 1, 2023. R3's diagnoses included hypertension, tracheostomy complications, and cognitive deficits following intracranial hemorrhage. On September 22, 2026, at 2:32 p.m., the surveyor observed R3 laying in his hospital bed with bilateral full bedrails in the up position. R3's Side-Rail Use Assessment Form was completed October 1, 2023.	02310		

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02310	Continued From page 99 R4 R4 was admitted and began receiving services on October 1, 2023. R4's diagnosis included acute ischemic stroke. On September 22, 2026, at 2:32 p.m., the surveyor observed R4's hospital bed which had bilateral upper half rails in the up position. R4's Side-Rail Use Assessment Form was completed October 1, 2023. On September 22, 2026, at 2:20 p.m., LALD/CNS-A stated side rail assessments were only completed on admission. The MDH website, Assisted Living Resources & FAQs indicated the following for consumer bed rails: - licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. - Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. - the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines - The licensee should offer alternatives, discuss and offer interventions to mitigate safety risks, and ensure the portable bed rail is installed and secured per manufacturer's guidelines. If the licensee elects to utilize a negotiated and/or mitigated risk agreement, the licensee must	02310		

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02310	Continued From page 100 maintain documentation of the offer of alternative, interventions to mitigate safety risks and conduct ongoing reassessment for the appropriate use of a bed rail. - If a licensee is unable to locate manufacturer's guidelines, they are unable to assess and determine if the portable bed rail is being used appropriately and installed properly. This results in an imminent safety risk for the resident/client. - Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. The MDH website, Assisted Living Resources & FAQs indicated the following for hospital bed rails included the following: - Per FDA recommendations, the need for bed rails must be assessed on a "frequent, regular basis." At a minimum this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took immediate action to mitigate risk; however, the scope and level remains at I.	02310		

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

HIGH DRIVE CUSTOMIZED ASSISTED LIVING
13813 HIGH DRIVE
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

License Info

License: HFID 39715

Risk:
License:
Expires on:
CFPM: Anbassa Hawiya Bukula
CFPM #: 67429; Exp: 05/12/2029

Inspection Info

Report Number: F1005261241
Inspection Type: Full - Single
Date: 9/22/2026 Time: 10:45 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! **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: INSTANCES OF EMPLOYEE ILLNESS ARE NOT BEING RECORDED. DISCUSSED RECORDING AND EXCLUSION REQUIREMENTS WITH PERSON IN CHARGE. BLANK LOG EMAILED WITH REPORT.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

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: THERE WAS NO INDICATOR ON SITE TO TEST THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. PROVIDE DISPOSABLE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO ENSURE THE DISHWASHER IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

Comply By: 9/29/2026 Originally Issued On: 9/22/2026

Food & Beverage General Comment

INSPECTION COMPLETED WITH FOOD MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR JENN PANITZKE.

THERMOLABELS WERE LEFT ON SITE FOR OPERATOR TO TEST DISHWASHER. OPERATOR SENT INSPECTOR A PICTURE OF THE LABEL AFTER RUNNING IT THROUGH THE DISHWASHER, SHOWING IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005261241 from 9/22/2026

ANBASSA BUKULA

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@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

HIGH DRIVE CUSTOMIZED ASSISTED LIVING
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1005261241
Inspection Type: Full
Date: 9/22/2026
Time: 10:45 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

HIGH DRIVE CUSTOMIZED ASSISTED LIVING
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1005261241
Inspection Type: Full
Date: 9/22/2026
Time: 10:45 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dishwasher
Location: Equal To 160 Degrees F.
Comment: BETWEEN 160 AND 170 PER THERMOLABEL
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39715016-0	**Date:** September 22, 2026
Facility Name: HIGH DRIVE CUSTOMIZED ASSISTED	
Facility Address: 13813 High Dr, Burnsville, Minnesota 55337	

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Isolated **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 extinguisher in the basement was not serviced since July of 2024 and had no record of monthly checks.

☒ **TAG IDENTIFICATION: 0800**

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

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

   Comments:

   Room number five (5) had a large water stain on the ceiling and chipping and peeling paint on the wall.

   Room number five (5) was missing all outlet covers on all the outlets.

   Electrical outlet in the kitchen near the front door was in disrepair.

   The basement bathroom was missing a light cover on the ceiling light and had chipping and peeling paint on the ceiling.

   Bedroom number six (6) had chipping and peeling paint on the ceiling.

Several deck boards were deteriorating throughout the deck.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The licensee failed to provide employee actions for evacuation to the surveyor during survey. The FSEP did not include any site-specific policies for staff procedures during evacuation. Site-specific plans should be included for employees in the FSEP.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide evacuation plans that include procedures for resident movement including the identification of unique or unusual resident needs for movement or evacuation.

3. 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 adequate record of staff training on the FSEP. Staff should be trained on the FSEP upon hire and at least twice a year thereafter.

4. 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 overnight fire drills.

5. 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: Several rooms were missing room numbers, including FSEP maps.