



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 14, 2026

Licensee
Caring Angels
9130 Louisiana Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL38746016

Dear Licensee:

On December 17, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 13, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 13, 2025 survey.

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a long horizontal flourish extending to the right.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/17/2025
NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL38746016-1 On December 16, 2025, through December 17, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 13, 2025. At the time of the survey, there were three (3) residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (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}			

Minnesota Department of Health

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{0 480}	Continued From page 2 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:	{0 480}	Not reviewed during this survey.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	{0 780}			

Minnesota Department of Health
STATE FORM 6899 CBIS12 If continuation sheet 4 of 12

Minnesota Department of Health
STATE FORM

Minnesota Department of Health

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{01500}	Continued From page 5 (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. Any training on hearing loss provided under this subdivision must be high quality and research	{01500}			

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{01500}	Continued From page 6 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for two of three unlicensed personnel ((ULP)-A, ULP-F). 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: ULP-A ULP-A was hired on April 19, 2023.	{01500}			

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{01500}	Continued From page 7 ULP-A's My Transcript - [ULP-A's name] dated December 16, 2025, was provided by ULP-B and identified by clinical nurse supervisor (CNS)-D as ULP-A's complete annual training transcript. The transcript indicated ULP-A last completed the course of Assisted Living Bill of Rights - MN (Minnesota) on January 8, 2023, and lacked evidence ULP-A completed a review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures. ULP-F ULP-F was hired on November 10, 2022. ULP-Fs My Transcript - [ULP-Fs name] dated December 16, 2025, was provided by ULP-B and identified by CNS-D as ULP-F's complete annual training transcript. The transcript indicated ULP-F last completed the course of Assisted Living Bill of Rights - MN on November 12, 2022, and lacked evidence ULP-F completed a review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures. On December 16, 2025, at 12:45 p.m., ULP-B and CNS-D stated the licensee would need to audit employee transcripts to ensure all annual training was completed. CNS-D stated they were the person responsible to assign the required annual trainings and they believed they had assigned all required annual trainings, but staff may have not completed the trainings. The licensee's 5.06 Annual Required Staff Training policy dated October 31, 2025, correctly identified all required annual trainings to be complete by each employee and evidence of the	{01500}			

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{01500}	Continued From page 8 completed trainings would be maintain in each employee's record. No further information was provided.	{01500}			
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the	{01530}			

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{01530}	Continued From page 9 requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure all employees received two (2) hours of mental illness training for three of three unlicensed personnel ((ULP)-A, ULP-B, and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on April 19, 2023. ULP-A's My Transcript - [ULP-A's name] dated December 16, 2025, was provided by ULP-B and identified by clinical nurse supervisor (CNS)-D as ULP-A's complete training transcript. The transcript indicated ULP-A completed the course of Mental Illness on August 1, 2025, and received .75 credit hours or 45 minutes of training. No	{01530}			

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{01530}	Continued From page 10 additional mental illness training was documented in ULP-A's training record. ULP-B ULP-B was hired on February 5, 2023. ULP-B's My Transcript - [ULP-B's name] dated December 16, 2025, was provided by ULP-B and identified by CNS-D as ULP-B's complete training transcript. The transcript indicated ULP-B completed the course of Mental Illness on July 25, 2025, and received .75 credit hours or 45 minutes of training. No additional mental illness training was documented in ULP-B's training record. ULP-F ULP-F was hired on November 10, 2022. ULP-F's My Transcript - [ULP-F's name] dated December 16, 2025, was provided by ULP-B and identified by CNS-D as ULP-F's complete training transcript. The transcript indicated ULP-F completed the course of Mental Illness on December 7, 2025, and received .75 credit hours or 45 minutes of training. No additional mental illness training was documented in ULP-F's training record. On December 16, 2025, at 12:45 p.m., ULP-B and CNS-D stated the licensee would need to audit employee transcripts to ensure each employee completed the required number of hours for mental illness training. CNS-D stated the licensee had an outside consultant assist them in assigning the required mental illness training. CNS-D stated the licensee had a policy and procedure which indicated the required number of hours, and the licensee had not assigned the full 2 hours of mental illness	{01530}			

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{01530}	Continued From page 11 training. The licensee's 5.03 Dementia, Mental Illness & De-escalation Training policy dated June 2025, indicated 2 hours of mental illness training would be completed and evidence of the training would be maintained in the employee's record. No further information was provided.	{01530}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 22, 2025

Licensee
Caring Angels
9130 Louisiana Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL38746016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$500.00

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
(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: SL38746016-0 On June 9, 2025, through June 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330			

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

TITLE

(X6) DATE

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. 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 the residents). The findings include: R2'S START DATE On June 9, 2025, at 9:18 a.m., owner (O)-E stated the licensee was currently serving two residents. On June 9, 2025, at 10:39 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D and unlicensed personnel (ULP)-B stated the licensee's current census was two residents and the last resident had discharged about two years ago as they had passed away in	0 330			

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0 330	Continued From page 2 the home around the same time the licensee had been surveyed in 2023. On June 9, 2025, at 11:12 a.m., ULP-B stated the current resident census was three residents as the licensee had admitted a new resident (R2) just one or two days ago. On June 9, 2025, at 12:31 p.m., during a tour of the facility, ULP-B stated R2 had slept at the facility since Saturday (June 7, 2025). CNS-D stated they had completed an assessment for R2. CNS-D stated R2 had brought his medications with, however CNS-D was not sure what R2 needed to take so they had a call into R2's provider to clarify and was waiting for a response. On June 10, 2025, at 9:13 a.m., the surveyor requested all records for R2. ULP-B stated the licensee did not print a contract for R2 to sign yet as the licensee had five days to complete and were actively working on this for R2. The surveyor requested R2's assessment that had been indicated to be completed by CNS-D on June 9, 2025. CNS-D stated R2's medication portion on the assessment had not been completed yet. The surveyor asked CNS-D and ULP-B if the licensee had documented services provided to R2. ULP-B stated the licensee had documented on services provided to R2. On June 10, 2025, at 10:16 a.m., they surveyor received records from CNS-D. CNS-D stated they did not feel confident with the records provided as they were not complete. On June 11, 2025, at 8:14 a.m., ULP-A stated they had just started working with R2. ULP-A stated R2 moved into the facility on Saturday June 7, 2025. ULP-A stated they assisted R2 with	0 330			

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0 330	Continued From page 3 meals, medications, laundry, and transportation. ULP-A stated they had not documented any medications given yet as they had not been able to see the tasks to document in the licensee's electronic record. During the interview, ULP-A asked the surveyor if they could check the licensee electronic system to see if they were able to document on R2 yet. The surveyor observed ULP-A going on the computer. ULP-A stated it was not there yesterday and was not there again today after they checked the computer. On June 11, 2025, at 8:44 a.m., R2 stated they had moved into the facility on Saturday (June 7, 2025). On June 11, 2025, at 9:04 a.m., the surveyor asked CNS-D about documentation on R2's mediation administration record (MAR) since June 1, 2025. CNS-D stated R2's case manager had called the licensee and asked if the resident could move into the facility. CNS-D stated the resident had been at the facility last year but would come and go a few times but just come back on Saturday. CNS-D reported R2 had moved to Chicago. CNS-D stated R2 first came to the facility August 2024 but was only at the facility for three days and then just disappeared. CNS-D stated R2 had called the facility about two weeks later to report he had moved to Chicago. CNS-D stated the police had brought his luggage to the facility August of 2024 as R2 had completed a change of address and the facility's address was inside of R2's luggage. CNS-D stated even this month, R2 had been coming and going. CNS-D stated R2 was still unpacking. CNS-D stated they were still trying to get R2's medications and complete the assessment on R2. CNS-D stated the licensee had five days to	0 330			

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0 330	Continued From page 4 complete the assessment and paperwork and stated this would be completed by Thursday this week. CNS-D stated R2 was in the electronic system as a potential resident but was just added as a resident as of June 7, 2025. On June 11, 2025, at 9:50 a.m., the surveyor asked CNS-D regarding the documentation prior to June 7, 2025, CNS-D stated R2 did not fully move in, and his medication assessment was not fully completed. CNS-D stated since R2 was in the electronic system as a potential resident, the staff had been documenting on the medication because he would come and go. CNS-D stated the staff documented on the medications even if the resident was outside of the facility or at the facility. CNS-D stated R2 only rented the room and was not getting any services. CNS-D stated since R2 had come back from Chicago, they had lost all their coverage to pay for housing and services. CNS-D stated R2's service had not been started and R2 officially moved in on Saturday as a resident. The surveyor asked CNS-D when R2 had moved into the facility as an independent resident. CNS-D stated they could not give the surveyor a date since R2 would come and go. The surveyor asked CNS-D when R2 started to pay rent to the licensee. CNS-D stated June as R2 gave them cash. The surveyor asked when R2 had moved back from Chicago. CNS-D stated R2 had come back in May, but they did not know. On June 11, 2025, at 11:54 a.m., the surveyor requested ULP-B to look up R2 on the licensee's electronic record to view records and different reports on R2. The surveyor requested licensee to email the following reports found in the licensee's electronic records: profile, notes dated March 1, 2024, to June 11, 2025, Service recap	0 330			

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0 330	Continued From page 5 summary from March 2024, assessment history, individualized medication management plan, MAR for May, MAR for April, service plan R2's Resident Profile as of June 11, 2025, indicated the following: R2's intake date was March 1, 2024; recent vitals on May 23, 2025, at 2:26 p.m. included a blood glucose was 215; and recent vitals on June 4, 2025, at 7:14 p.m. included blood pressure (BP) of 193/125, oxygen saturation (O2 Sat) was 92, pulse was 87, respiration was 16, temperature was 97.8, and bowel movement (BM) was three. R2's Resident Notes - Included Service Notes dated March 1, 2024, to June 11, 2025, indicated CNS-D had written a note on May 23, 2025, at 2:26 p.m. The note indicated the following: R2 was alert and orientated; appeared calm and stable mood; staff reported R2 was aggressive and angry about their bowl being used the day prior; staff had calmed R2 down; R2's vitals were stable except BP was slightly elevated; emphasized importance of taking medications and not spitting them out; R2 was reported to verbalize understanding and reassured the nurse they did not spit out medications; and registered nurse (RN) and staff would continue to monitor. R2's Resident Notes - Included Service Notes dated March 1, 2024, to June 11, 2025, indicated CNS-D had written a note on May 23, 2025, at 2:30 p.m. The note indicated the following: R2 was alert and orientated; R2 complained of hip pain; nurse asked R2 about pain medication not in the medication list and asked if R2 took any as needed pain medications as they needed to clarify in case they took any as needed pain medication left in the kitchen; and nurse indicated they were going to contact R2's primary and	0 330			

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0 330	Continued From page 6 mental health clinics to complete medication reconciliation. R2's Med Summary - Actual - Month dated May 2025, indicated the licensee documented on medications administered at 1:00 p.m. and 2:00 p.m. from May 23, 2025, through May 31, 2025. ROOM OCCUPANCY On June 9, 2025, at 10:00 a.m., upon arrival to the facility, ULP-F showed surveyor room five on the lowest level of the home. The surveyor observed room five had a bed that was made with linens and pillows, portable closet that zipped open and closed, small mirror with vanity full of personal makeup and hygiene items, chair, recliner, dresser, and television stand. ULP-F stated room five was vacant. ULP-F stated staff leave their things in the room, but staff was not living in the room. The surveyor observed ULP-F move a chair, cleared a small television stand, and move the television stand toward the chair in the center of the room for the surveyor to use during the surveyor process. On June 9, 2025, at 12:31 p.m., during a tour of the facility, the surveyor observed room five again. ULP-B stated staff did not stay in room five; and the licensee allowed R3 to leave their personal items in the room as R3 had a lot of things. ULP-B then pointed out the chair, recliner, dresser, television stand, and portable closet were all R3's personal items. ULP-B stated the vanity was R5's as well but the make-up and personal hygiene items on the vanity were staffs. The surveyor observed ULP-A quickly packing up the items on the vanity and placing them in a bag. On June 11, 2025, at 8:56 a.m., during a resident interview, the resident was asked if they ever	0 330			

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0 330	Continued From page 7 needed to call for assistance at night. The resident responded to the surveyor and said they have asked for assistance at night as they came out of their room and knocked on the door. The surveyor confirmed the resident was referencing room five's door. The surveyor asked the resident if the staff slept in room five; the resident stated yes, I think they are downstairs. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond	0 340			

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0 340	Continued From page 8 to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed July 19, 2023. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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 the residents). The findings include: On June 9, 2025, at 10:39 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D and unlicensed personnel (ULP)-B stated the licensee was familiar with current minimum assisted living requirements. On August 10, 2023, the licensee received an enforcement letter, with the results of the survey completed July 19, 2023. The longest period for correction was 21 days from August 10, 2023, to August 31, 2023. The licensee's survey completed on July 19, 2023, identified non-compliance in the following areas, which were also identified during the	0 340			

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0 340	Continued From page 9 survey completed on June 13, 2025: 0495, 0680, and 0650. The licensee's undated Corrections Order Compliance Document, lacked documentation to indicate correction orders for 0495, 0680, and 0650 previously cited on July 19, 2023, were in full compliance with assisted living statutes. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
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 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	0 420			

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0 420	Continued From page 10 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license, effective May 20, 2025. 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 believe, 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 (O-E) on February 21, 2025. As a result of this survey, the following orders	0 420			

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0 420	Continued From page 11 were issued under 0330, 0340, 0420, 0430, 0470, 0480, 0485, 0510, 0630, 0640, 0650, 0660, 0680, 0690, 0780, 0790, 0810, 0900, 0970, 1370, 1380, 1440, 1500, 1530, 1610, 1620, 1640, 1700, 1730, 1760, 1790, 1820, 1880, and 1910, 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			
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by:	0 430			

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0 430	Continued From page 12 Based on interview and record review, the licensee failed to provide the licensee's accurate Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) for one of one resident (R1) who had been discharged. 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 the residents). The findings include: R1 was admitted on October 23, 2023, with diagnoses of Parkinson's disease, arthritis, chronic back pain, and spinal stenosis. R1 was discharged on February 12, 2024, from the licensee to another assisted living facility. R1's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated September 1, 2023, was signed by R1 on October 23, 2023. R1's UDALSA indicated under section, Mobility Services Available, the licensee would have the service available for transfers with assist of two staff. On June 10, 2025, at 2:45 p.m., unlicensed personnel (ULP)-B stated R1 had left the facility on their own, so the licensee did not provide a termination notice. ULP-B stated R1's power of attorney was not happy with the licensee as they did not have two-person assist with transfers and unfortunately R1's care needs were more then what the licensee could provide. ULP-B stated the	0 430			

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0 430	Continued From page 13 resident wanted to walk with two staff and did not want to use an assistive device. Also, ULP-B stated R1 had lots of pain and wanted pain medications earlier then prescribed and would get upset that staff locked her pain medication up. On June 12, 2025, at 11:34 a.m., clinical nurse supervisor (CNS)-D stated, "sometimes you run into understaffing so then what do you do?" CNS-D stated R1 had come to the facility as a one person assist but after going to the hospital, they needed that two-person transfer. CNS-D stated they had provided R1 with two staff after her hospitalization. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy dated November 1, 2022, indicated the licensee would always keep the UDALSA current and any changes made to the UDALSA would be sent to Minnesota department of Health. The facility UDALSA would list all services and amenities the facility offers to provide and does not provide. No further information provided. TIME PERIOD TO CORRECT: Seven (7) days	0 430			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans	0 470			

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0 470	Continued From page 14 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 develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) at least twice a year; and failed to post a 24-hour staffing schedule in a central location. 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) 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).	0 470			

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0 470	Continued From page 15 The findings include: STAFFING PLAN On June 9, 2025, at 10:39 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D stated the licensee's staffing schedule consisted of two twelve-hour shifts for their unlicensed personnel. CNS-D and unlicensed personnel (ULP)-B stated they did not know what a staffing plan was. The surveyor referred the licensee to MN Statue 144G.41 Subdivision 1 (11-12). CNS-D and ULP-B stated they discussed the staffing needs all the time but did not document it. The licensee's Facilityt (sic) Staffing Plan reviewed February 24, 2025, indicated the staffing plan was prepared by licensed assisted living director (LALD)-C. The plan lacked evidence of being reviewed at least twice a year by a clinical nurse supervisor (CNS). The staffing plan identified three shifts which did not reflect the current staffing schedule for the facility. POSTED SCHEDULE On June 9, 2025, at 12:31 p.m., the surveyor observed an undated staff schedule posted in the living room by the main entrance of the facility. On June 9, 2025, at 1:39 p.m., the surveyor observed ULP-B reviewing the undated schedule posted in the living room. ULP-B stated the schedule posted was from two months ago as they remembered ULP-G listed on the schedule was on-call for ULP-F. ULP-B confirmed the licensee did not have current schedule posted. ULP-B stated they were aware of the need to have a schedule posted but did not know how often it needed to be posted.	0 470			

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0 470	Continued From page 16 On June 11, 2025, at 3:25 p.m., LALD-C stated the schedules should have been posted; and it was an oversight. The licensee's Staffing & Scheduling policy dated November 1, 2022, indicated CNS would develop and implement a written staffing plan that provided adequate number of qualified direct-care staff to meet the resident needs 24-hours a day, seven days a week. The policy indicated CNS must ensure staffing levels are adequate to address resident needs, acuity as determined by the most recent assessment, ability of staff to timely meet the residents scheduled and reasonably foreseeable unscheduled needs, staff experience, training, and competency. Also, the policy indicated CNS would develop a 24-hour daily staffing schedule that must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480			

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0 480	Continued From page 17 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	0 480			

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0 480	Continued From page 18 (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) 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, Food and Beverage Establishment Inspection Report (FBEIR) dated June 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious	0 485			

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0 485	Continued From page 19 meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have menus prepared at least one week in advance and made available to all residents. This had the potential to affect all residents. 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 the residents). The findings include: On June 9, 2025, at 12:31 p.m., the surveyor observed a resident menu posted in the kitchen that was dated January 2024. Unlicensed personnel (ULP)-B stated the licensee notified the	0 485			

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0 485	Continued From page 20 resident of the advance meal plans by posting the menu in the kitchen. The surveyor asked about the menu posted with a date of January 2024. ULP-B stated they were just using this menu and were offering the same meals on the menu every week and if the resident did not like a meal, then they could have an alternative meal. ULP-B stated sometimes the resident would go to the grocery store with staff or the resident would cook their own culture foods or would ask staff to do that. On June 11, 2025, at 8:56 a.m., ULP-B stated they asked licensed assisted living director (LALD)-C why they did not have the two-week menu; and provided the surveyor with a current menu. ULP-B stated the licensee had the menu, but it was just not at the facility; and that was why they called LALD-C. The licensee's Food Service & Menu Planning policy dated November 1, 2022, indicated menus would be prepared at least one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510			

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0 510	Continued From page 21 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: HAND SOAP On June 9, 2025, at 12:31 p.m., during a tour of the facility, the surveyor observed the bathroom on the upper level of the facility, next to resident rooms, did not have hand soap, hand sanitizer, or hand towels for washing and drying hands. On June 12, 2025, at 10:22 a.m., clinical nurse supervisor (CNS)-D stated staff would be expected to wash their hands in the kitchen sink.	0 510			

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0 510	Continued From page 22 CNS-D stated the residents have their own towels and personal grooming supplies in the bathrooms so that may be why there was no soap and towels. After the surveyor confirmed with CNS-D, staff would need to wash their hands after using the bathroom at the kitchen sink, CNS-D stated staff would be expected to wash hands in the bathroom and use the soap available in the bathroom. CNS-D then stated the facility bought the soap for the bathrooms. HAND WASHING/GLOVE USE On June 10, 2025, at 8:58 a.m., the surveyor observed unlicensed personnel (ULP)-A wash hands at the kitchen sink, apply gloves, prepare resident's (R4) medications to take outside of the facility. ULP-A then walked outside of the facility with R4, while they stated, they were going to tell the driver and give the medications to the driver. The surveyor observed ULP-A walk back into the facility wearing the same gloves. ULP-A then removed the gloves but did not wash their hands after removing the gloves. On June 11, 2025, at 9:26 a.m., the surveyor observed ULP-A wash their hands with soap and use hand sanitizer in the kitchen, applied gloves, checked R3's blood pressure on left wrist, checked blood glucose on R3's libre system, then administered eye drops in both eyes for R3. ULP-A then proceeded in the kitchen, removed a pot from the stove, placed under running water, deshelled hard-boiled eggs while still wearing the same gloves, and then served the hard-boiled eggs to R3. On June 12, 2025, at 10:22 a.m., CNS-D stated they expected staff to remove gloves after staff had administered eye drops and placed the medication back in storage. CNS-D stated the	0 510			

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0 510	Continued From page 23 staff should be washing hands immediately after removing gloves. The licensee's Infection Control policy dated November 1, 2022, indicated the licensee's infection control program would be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The Centers for Disease Control and Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings dated October 25, 2002, on page 32, indicated recommendations for handwashing and hand antisepsis to be performed before direct contact with patient (resident); after direct contact with a patient's intact skin; after contact with body fluids or excretions, mucous membranes, nonintact skin or wound dressings; moving from a contaminated-body site to a clean-body site during patient care; after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; after removing gloves, before eating and after using restroom. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630			

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0 630	Continued From page 24 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster. However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's unsigned Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication administration. R2's Individual Abuse Prevention Plan - As of	0 630			

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0 630	Continued From page 25 Date dated June 7, 2025, lacked an assessment of the person's risk of abusing other vulnerable adults. R3 R3 was admitted to the licensee on November 4, 2022, with diagnosis of diabetes. R3's Service Plan Form dated September 19, 2024, indicated R3 received assistance with medication administration. On June 11, 2025, at 9:26 a.m., the surveyor observed ULP-A assist R3 with medication administration. R3's Individual Abuse Prevention Plan - As of Date dated June 9, 2023, indicated R3 was at risk to be abused but lacked statements of the specific measures to be taken to minimize the risk of abuse to that person. Also, R3's IAPP lacked an assessment of the person's risk of abusing other vulnerable adults. On June 12, 2025, at 11:52 a.m., clinical nurse supervisor (CNS)-D stated they were not aware of the Minnesota Statute; and R2's IAPP was not completed yet. The licensee's Individual Abuse Prevention Plan policy dated November 1, 2022, the plan would contain an individualized review or assessment of the person's risk of abusing other vulnerable adults and statements of the specific measure to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630			

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NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
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0 630	Continued From page 26 days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information for reporting to Minnesota Adult Abuse Reporting Center (MAARC); and failed to post 911 emergency number in common areas. 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).	0 640			

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0 640	Continued From page 27 The findings include: On June 9, 2025, at 12:31 p.m., during the facility tour, the surveyor did not observe information posted for reporting crime and suspected maltreatment to MAARC or posted 911 emergency number in a common area of the facility. On June 11, 2025, at 3:19 p.m. licensed assisted living director (LALD)-C stated they were not aware of the statue. The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated November 1, 2022, indicated the licensee would post information for reporting suspected crime and maltreatment by posting 911 emergency number in common areas, information on Minnesota Adult Abuse Reporting Center and the contact number to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650			

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0 650	Continued From page 28 (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 interview and record review, the licensee failed to ensure employee records included all required content for two of two unlicensed personnel ((ULP)-A, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on April 19, 2023. ULP-A's employee record lacked evidence of the following required content:	0 650			

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0 650	Continued From page 29 - job description; - an annual performance review for 2024 that identified areas of improvement needed along with additional training needs; - competency evaluation for appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - competency evaluation for standby assistance techniques and how to perform them; - competency evaluation for reading and recording temperature, pulse, and respirations of the resident; - competency evaluation for safe transfer techniques and ambulation; - competency evaluation for range of motion and positioning; and - competency evaluation for administering medications or treatments including blood glucose monitoring as required. On June 11, 2025, at 8:14 a.m., ULP-A stated the licensee's previous registered nurse and clinical nurse supervisor (CNS)-D had provided training on medications, vital signs, personal cares/hygiene, range of motion, transfers, and blood glucose. ULP-A stated they had to return demonstration to the nurse before they provided the cares. ULP-B ULP-B was hired on February 5, 2023. ULP-B's employee record lacked evidence of the following required content: - an annual performance review for 2024 that identified areas of improvement needed along with additional training needs;	0 650			

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0 650	Continued From page 30 - competency evaluation for reading and recording temperature, pulse, and respirations of the resident; and - competency evaluation for administering medications or treatments including blood glucose monitoring as required. On June 10, 2025, at 11:36 a.m., ULP-B confirmed all personnel records received by the surveyor was everything the licensee had for competencies and if the competency was not in the record, then they did not document the competency. ULP-B stated they were trained and observed by the previous nurse and by CNS-D. On June 10, 2025, at 2:00 p.m., ULP-B stated they did have training on personal cares, transfers, and range of motion through Educare (a common online education program) and through their certified nurse assistant (CNA) at the time of hire. ULP-B stated they were not training by the nurse for these. ULP-B confirmed they did not renew their CNA as it was only completed as a requirement to get into nursing school at the time. ULP-B then confirmed they did train and return demonstration with the nurse for medications, blood glucose, vital signs including oxygen saturations after they had completed the education in Educare. On June 11, 2025, at 3:28 p.m., licensed assisted living director (LALD)-C stated they were aware of the required content for personnel records. LALD-C stated the licensee performed 30-day supervisions that reviewed medication and communication, then after the 30-day, the licensee would do an annual performance review. LALD-C stated they had a separate folder for all the performance reviews as they had removed them from the personnel record prior to leaving	0 650			

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0 650	Continued From page 31 out of country. On June 12, 2025, at 10:48 a.m., CNS-D stated they were not aware of the training and competency requirements in Minnesota Statue. CNS-D stated they had provided training on medication, personal hygiene; grooming; dressing; transfers; mobility; assistive devices; toileting; range of motion; blood glucose monitoring; and reading and recording temperature, pulse, and respirations of the resident. The licensee's Employee Records policy dated November 1, 2022, indicated employee records for each person would include the following: - current signed job description; - documentation of annual performance reviews that identified areas of improvement needed and training needs; and - records of competency testing as required. 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	0 660			

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0 660	Continued From page 32 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment and a baseline TB screening that included a two-step tuberculin skin test (TST) or other evidence of TB testing such as IGRA (a blood test) for two of two unlicensed personnel ((ULP)-A, ULP-B). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT The licensee's Facility TB Risk Assessment dated April 2022, was completed on July 18, 2024. The assessment identified the national rate was 2.9 percent and the Minnesota rate was 2.8 percent	0 660			

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0 660	Continued From page 33 for 2023. The assessment form and data used to complete the incidence of TB was not current information at the time the assessment was completed. On June 10, 2025, at 8:37 a.m., clinical nurse supervisor (CNS)-D stated they would look up the national and the Minnesota rates for TB every year instead of using the most current Facility TB Risk Assessment form that had the current national and Minnesota rates of TB. ULP-A ULP-A was hired on April 19, 2023. On June 11, 2025, at 9:26 a.m., the surveyor observed ULP-A assist R3 with medication administration. ULP-A's personnel record lacked documentation of a baseline TB screening that included assessment for current symptom of active TB disease, assessment for TB history, and testing for the presence of infection with mycobacterium tuberculosis by administration of either a two-step TST or a single blood test such as an IGRA. ULP-B ULP-B was hired on February 5, 2023. On June 10, 2025, at 1:37 p.m., the surveyor observed ULP-B checking R4's blood glucose via Dexcom (continuous blood glucose monitor system). ULP-B's IGRA collected on June 20, 2023, indicated a positive result for TB. The TB testing was completed 135 days after ULP-B was hired by the licensee.	0 660			

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0 660	Continued From page 34 ULP-B's IGRA collected on July 19, 2024, indicated a positive result for TB. ULP-B's Baseline TB Screening Tool for Health Care Workers (HCWs) dated July 29, 2024, indicated the TB screening for current symptom of active TB disease and TB history was completed 540 days after ULP-B was hired by the licensee. ULP-B's chest x-ray letter dated July 29, 2024, indicated a chest x-ray was negative but did not indicate a provider evaluation for the positive TB result. On June 11, 2025, at 3:04 p.m., licensed assisted living director (LALD)-C stated they were not aware of the TB requirements. LALD-C stated the licensee usually would have employee's get the TB screening and TB testing within 30 days of hire. LALD-C stated the nurse would be the one to coordinate the TB screening. On June 12, 2025, at 12:14 p.m., CNS-D stated they were aware of the TB requirements. CNS-D stated ULP-A and ULP-B had been hired prior to CNS-D. CNS-D stated they should have reviewed the records but had assumed they were ok. The licensee's Tuberculosis Screening policy dated November 1, 2022, indicated staff whose essential job function require work within the same air space of the residents would be screened and tested for TB prior to staff being exposed to residents; and baseline (upon hire) screening would be completed. The licensee's Employee Records policy dated November 1, 2022, indicated employee records would include verification that required health	0 660			

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0 660	Continued From page 35 screenings for TB have taken place for individuals who provided assisted living services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680			

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0 680	Continued From page 36 Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z; and failed to post the EPP prominently. 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) 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: On June 9, 2025, at 12:31 p.m., during the facility tour, the surveyor did not observe the full EPP posted prominently. The licensee's undated EPP lacked evidence of the following required content: - process for EP collaboration; - subsistence needs for staff and patients; - procedures for tracking of staff; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - names and contact information; - emergency officials contact information; - sharing information on occupancy/needs; - LTC family notifications; - emergency prep training program; and - emergency prep testing requirements. On June 12, 2025, at 9:28 a.m., the surveyor asked unlicensed personnel (ULP)-B where the emergency supplies were located. ULP-B stated	0 680			

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0 680	Continued From page 37 licensed assisted living director (LALD)-C would know where to find them. On June 12, 2025, at 9:45 a.m., the surveyor asked clinical nurse supervisor (CNS)-D where the emergency supplies were located. CNS-D was observed talking to ULP-B in another language in front of the surveyor and then asked the surveyor, "like, the first aid kit? ULP-B stated LALD-C told her they have the emergency supplies. CNS-D was then observed looking in the kitchen cupboard and hallway closet. On June 12, 2025, at 2:04 p.m., the surveyor asked LALD-C if they had written agreements for alternative locations in the event the facility needed to evacuate. LALD-C stated it would be at another group home and a religious place; however, they were not sure why it was not in the EPP binder. LALD-C stated they were working on emergency supplies and that was why they were not at the facility. LALD-C stated if something was not in the EPP binder, then they were working on it. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated December 2, 2024, indicated the licensee would have a plan in place that was effective and compliant. The policy indicated the EPP would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 690	Continued From page 38	0 690			
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were permanently recorded, current, and authenticated with the name and title of the person making the entry for one of one resident (R3). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On June 11, 2025, at 9:26 a.m., the surveyor observed ULP-A monitoring R3's blood pressure. The surveyor observed R3's blood pressure was 167/105. ULP-A wrote the reading on paper. The surveyor did not observe ULP-A rechecking the blood pressure or notifying the nurse of the high blood pressure. R3 was admitted to the licensee on November 4, 2022, with diagnosis of hypertension.	0 690			

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0 690	Continued From page 39 R3's Service Plan (Waiver) - Addendum to Contract dated December 4, 2022, indicated R3 received blood pressure recording daily. R3's Vital Signs - One Resident dated May 1, 2025, through June 12, 2025, indicated R3's blood pressure on June 11, 2025, AM (morning) was documented as 155/71. R3's vital sign report lacked any other documented blood pressure on June 11, 2025. On June 12, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-D stated staff would normally notify the nurse for high blood pressures and did not know why they were not notified on June 11, 2025. CNS-D stated they would have instructed ULP-A to recheck the blood pressure. CNS-A stated they would provide retraining to staff. On June 12, 2025, at 1:40 a.m., the surveyor observed CNS-D calling ULP-A and spoke in another language. CNS-D stated ULP-A had documented the blood pressure reading in a notebook but just had not documented the blood pressure reading in the record yet; and the other blood pressure reading on the report was an earlier blood pressure. CNS-D stated R3 gets her blood pressure daily but sometimes twice a day. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780			

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NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
(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
0 780	Continued From page 40 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and 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	0 780			

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0 780	Continued From page 41 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 10, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-B and unlicensed personnel (ULP)-A. The surveyor asked ULP-B to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. The facility had hardwired (receiving power from the building electrical system) smoke alarms installed in the main level dining room, hallway and bedrooms 1, 2, and 4. The same areas also had battery operated smoke alarms installed adjacent to the hardwired smoke alarms. All smoke alarms in the facility must be interconnected. Existing hardwired smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms so activation of one alarm activates all alarms throughout the facility. These deficient conditions were visually verified by ULP-B and ULP-A accompanying on the tour. On June 10, 2025, at 11:00 a.m., ULP-B stated they installed new, battery operated smoke alarms to comply with the interconnection requirements of the license because the existing hardwired smoke alarms were not interconnected.	0 780			

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0 780	Continued From page 42	0 780			
	TIME PERIOD FOR CORRECTION: Seven (7) days.				
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: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. 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). The findings include: On June 10, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with unlicensed	0 790			

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0 790	Continued From page 43 personnel (ULP)-B and unlicensed personnel (ULP)-A. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. These deficient conditions were visually verified by ULP-B and ULP-A accompanying on the tour. On June 10, 2025, at 11:00 p.m. ULP-B stated they did not know the monthly checks were not being done. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810			

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0 810	Continued From page 44 (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 develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 10, 2025, unlicensed personnel (ULP)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810			

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0 810	Continued From page 45 evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety, dated December 7, 2023, Fire Safety 9.06, dated December 6, 2024, and ResidenWolunteer(sic) Emergency Training, dated December 6, 2024, failed to include the following: The licensee failed to develop and maintain their FSEP. The licensee provided multiple policies from multiple third-party provider groups for the surveyor to review. None of the policies reviewed met all the requirements for the FSEP listed in statute. Each policy had a different version of each requirement. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. ULP-B stated they would work on consolidating their FSEP into one, complete policy that included all required sections from statute. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. ULP-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.	0 810			

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0 810	Continued From page 46 The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ULP-B lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. On June 10, 2025, at 1:30 p.m., ULP-B stated the licensee completed a training for employees in 2024 as part their plan of correction from a previous survey. ULP-B stated the director does all the training for staff. ULP-B stated they did not remember receiving training on the FSEP in the last twelve months. ULP-B stated they provide training to residents who participate in the evacuation drills, but they did not document it. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, Emergency Drill Reporting Form, undated, indicated evacuation drills were conducted on January 10, 2024, February 26, 2024, March 12, 2024, July 4, 2024, September 1, 2024, December 6, 2024, and March 11, 2025. On June 10, 2025, at 1:30 p.m., ULP-B stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or	0 900			

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0 900	Continued From page 47 provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content 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	0 900			

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0 900	Continued From page 48 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster. However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's unsigned Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication administration. R2's clinical record lacked an executed written contract with the required content. On June 10, 2025, at 9:13 a.m., unlicensed personnel (ULP)-B stated the licensee did not print a contract for R2 since they were not actually admitted to the licensee until June 7, 2025, as the licensee had a five-day window and were actively working on getting the contract completed. The licensee's Signing an Assisted Living Contract policy dated November 1, 2022, indicated when a prospective resident decided to move into the facility, an assisted living contract is signed. No further information was provided.	0 900			

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0 900	Continued From page 49	0 900			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language that waived the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. 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 the residents). The findings include: On June 9, 2025, at 2:11 p.m., the licensee provided the surveyor with a blank contract used for all residents.	0 970			

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0 970	Continued From page 50 The licensee's undated Assisted Living Contract indicated under section, Indemnification, "[the licensee] shall not be liable for any damage or injury to the resident ...the resident agrees to hold [the licensee] harmless from any claims or damages unless caused solely by negligence of [the licensee]." On June 11, 2025, at 3:17 a.m., licensed assisted living director (LALD)-C stated they had just recently found out from a previous survey at a different facility that the licensee could not have a waiver of liability in the contract. LALD-C stated they will need to change the contract for this licensee. LALD-C stated they bought the contract from an provider group and had their trust in them that the contract would be sufficient. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing;	01370			

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01370	Continued From page 51 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for one of two unlicensed personnel (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 an isolated scope (when one or a	01370			

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01370	Continued From page 52 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 10, 2025, at 1:37 p.m., the surveyor observed ULP-B checking R4's blood glucose via Dexcom (continuous blood glucose monitor system). ULP-B was hired on February 5, 2023. On June 10, 2025, at 9:44 a.m., the surveyor confirmed ULP-B did not have a current Minnesota Nurse Aide certificate on the Minnesota Nurse Aide Registry. ULP-B's personnel record lacked evidence of completed training and/or competency for the following: - competency evaluation for appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - competency evaluation for standby assistance techniques and how to perform them; and - training on preparation of modified diets as ordered by a licensed health professional. On June 10, 2025, at 2:00 p.m., ULP-B stated they did have training on personal cares/hygiene and standby assistance techniques through Educare (a common online education program) and through their certified nurse assistant (CNA) at the time of hire. ULP-B stated they were not trained or had returned demonstration on personal cares/hygiene and standby assistance	01370			

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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
01370	Continued From page 53 techniques to the licensee's nurse. ULP-B confirmed they did not renew their CNA as it was only completed as a requirement to get into nursing school at the time. On June 12, 2025, at 10:48 a.m., CNS-D stated they were not aware of the training and competency requirements in Minnesota Statue. CNS-D stated they had provided training on medication, personal hygiene; grooming; dressing; transfers; mobility; assistive devices; toileting; range of motion; blood glucose monitoring; and reading and recording temperature, pulse, and respirations of the resident. On June 12, 2025, at 2:07 p.m., licensed assisted living director (LALD)-C stated the licensee's intention was to assign all the required trainings for all staff at hire through Educare (common online education program); and stated it was an oversight on missing training. The licensee's Competency Training Evaluations policy dated November 1, 2022, indicated training and competency evaluations for all ULP's would include the following: - appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - standby assistance techniques and how to perform them; and - preparation of modified diets as ordered by a licensed health professional. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01370			

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01370	Continued From page 54 (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competencies were completed and documented for one of two unlicensed personnel (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 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).	01380			

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01380	Continued From page 55 The findings include: On June 10, 2025, at 1:37 p.m., the surveyor observed ULP-B checking R4's blood glucose via Dexcom (continuous blood glucose monitor system). ULP-B was hired on February 5, 2023. On June 10, 2025, at 9:44 a.m., the surveyor confirmed ULP-B did not have a current Minnesota Nurse Aide certificate on the Minnesota Nurse Aide Registry. ULP-B's personnel record lacked evidence of completed competency evaluation for the following: - competency evaluation for safe transfer techniques and ambulation; and - competency evaluation for range of motion and positioning. On June 10, 2025, at 2:00 p.m., ULP-B stated they did have training on transfers, and range of motion through Educare (a common online education program) and through their certified nurse assistant (CNA) at the time of hire. ULP-B stated they were not trained or had returned demonstration on transfers or range of motion to the licensee's nurse. ULP-B confirmed they did not renew their CNA as it was only completed as a requirement to get into nursing school at the time. On June 12, 2025, at 10:48 a.m., CNS-D stated they were not aware of the training and competency requirements in Minnesota Statue. CNS-D stated they had provided training on medication, personal hygiene; grooming;	01380			

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01380	Continued From page 56 dressing; transfers; mobility; assistive devices; toileting; range of motion; blood glucose monitoring; and reading and recording temperature, pulse, and respirations of the resident. The licensee's Competency Training Evaluations policy dated November 1, 2022, indicated competency evaluation for ULP's that provided assisted living services would include the following: - safe transfer techniques and ambulation; and - range of motion and positioning. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff 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	01440			

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01440	Continued From page 57 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 the registered nurse (RN) completed supervision of unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for two of two unlicensed personnel (ULP-A, 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 potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on April 19, 2023. On June 11, 2025, at 9:26 a.m., the surveyor observed ULP-A assist R3 with medication administration. ULP-A's Supervision of Unlicensed Personnel dated December 3, 2023, June 10, 2024, and June 8, 2025, indicated the supervision was completed by licensed assisted living director (LALD)-C.	01440			

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01440	Continued From page 58 ULP-A's personnel record lacked evidence an RN conducted direct supervision of staff performing a delegated task within 30 days of providing services. ULP-B ULP-B was hired on February 5, 2023. On June 10, 2025, at 1:37 p.m., the surveyor observed ULP-B checking R4's blood glucose via Dexcom (continuous blood glucose monitor system). ULP-B's Supervision of Unlicensed Personnel dated December 3, 2023, June 10, 2024, and June 8, 2025, indicated the supervision was completed by LALD-C. ULP-B's personnel record lacked evidence an RN conducted direct supervision of staff performing a delegated task within 30 days of providing services. On June 12, 2025, at 1:20 p.m. CNS-D stated they were not aware of the statue and confirmed they had not performed any supervisions on staff. The licensee's Supervision of Staff - Delegated Services policy dated November 1, 2022, indicated staff who provided delegated nursing or therapy tasks to residents would be supervised by an RN or appropriate licensed health professional where the services were being provided to verify the work was performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Also, the policy indicated the direct supervision of staff performing the delegated tasks would be provided within 30 calendar days after the date on	01440			

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01440	Continued From page 59 which the individual began work for the licensee and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500			

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01500	Continued From page 60 (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following 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 two of two unlicensed personnel ((ULP)-A, 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	01500			

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01500	Continued From page 61 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 the residents). The findings include: ULP-A ULP-A was hired on April 19, 2023. On June 11, 2025, at 9:26 a.m., the surveyor observed ULP-A assist R3 with medication administration. ULP-A's personnel record lacked evidence of the following required topics of annual training in 2024: - reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. ULP-B ULP-B was hired on February 5, 2023. On June 10, 2025, at 1:37 p.m., the surveyor observed ULP-B checking R4's blood glucose via Dexcom (continuous blood glucose monitor system).	01500			

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01500	Continued From page 62 ULP-B's personnel record lacked evidence of the following required topics of annual training in 2024: - infection control techniques; and - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On June 12, 2025, at 11:10 a.m. clinical nurse supervisor (CNS)-D stated they were aware of the annual training requirements, but they did not manage the annual training as licensed assisted living director (LALD)-C managed it. On June 12, 2025, at 2:07 p.m., LALD-C stated they would assign all the annual trainings required by Statue through Educare (common online education program). LALD-C stated it was an oversight for the missing annual training and not following up. The licensee's Annual Required Staff Training policy dated November 1, 2022, indicated all staff that performed direct care services would complete at least eight hours of annual training for each 12 months of employment; and the following training elements must include the following: - reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures;	01500			

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01500	Continued From page 63 and - principles of person-centered planning/service delivery. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on	01530			

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01530	Continued From page 64 topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees received two (2) hours of annual dementia care training for direct care employees as required for two of two unlicensed personnel ((ULP)-A. 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) 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: ULP-A ULP-A was hired on April 19, 2023. On June 11, 2025, at 9:26 a.m., the surveyor observed ULP-A assist R3 with medication administration.	01530			

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01530	Continued From page 65 ULP-A's personnel record lacked two (2) hours of annual dementia care training in 2024. ULP-B ULP-B was hired on February 5, 2023. On June 10, 2025, at 1:37 p.m., the surveyor observed ULP-B checking R4's blood glucose via Dexcom (continuous blood glucose monitor system). ULP-B's personnel record lacked two (2) hours of annual dementia care training in 2024. On June 12, 2025, at 11:05 a.m. clinical nurse supervisor (CNS)-D stated they were not aware of the Statue and confirmed they have not provided any training on dementia. CNS-D stated licensed assisted living director (LALD)-C managed it through Educare (common online education program). On June 12, 2025, at 2:07 p.m., LALD-C stated they would assign all the annual dementia training as required by Statue through Educare. LALD-C stated it was an oversight for the missing dementia training and not following up. The licensee's Dementia Training policy dated November 1, 2022, indicated all staff would complete two hours of additional training for each 12 months of work. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

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01610	Continued From page 66	01610			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for one of three residents (R2) receiving 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	01610			

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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
01610	Continued From page 67 situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster. However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's unsigned Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication administration. R2's clinical record lacked an executed written contract with the required content. R2's record lacked an initial assessment that was completed prior to the date on which a prospective resident executed a contract with the facility or on the day the resident moved in. On June 10, 2025, at 9:13 a.m., clinical nurse supervisor (CNS)-D stated the medication portion of the assessment was not completed. On June 11, 2025, at 9:04 a.m., CNS-D stated R2 was still unpacking and trying to get their medications. CNS-D stated they still needed to complete the assessment which they thought they had a five-day window to do so. The licensee's Assessment Schedules policy dated November 1, 2022, indicated an initial resident nursing assessment would be completed prior to the date on which a prospective resident executes a contract or the date on which a prospective resident moved in, which ever was earlier.	01610			

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01610	Continued From page 68 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part	01620			

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01620	Continued From page 69 of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments and monitoring not to exceed 90 calendar days from the last date of assessment for one of three residents (R3). 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:	01620			

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01620	Continued From page 70 R3 was admitted to the licensee on November 4, 2022, with diagnosis of hypertension. R3's Assisted Living Contract dated November 5, 2022, but was signed on April 12, 2022. R3's Service Plan form dated September 19, 2024, indicated R3 received assistance with medication administration. R3's record included 90-day nursing assessments completed on September 19, 2024, December 13, 2024, and March 28, 2025. The 90-day assessment completed on December 13, 2024, indicated 105 days had passed since the previous 90-day assessment completed on March 28, 2025. On June 12, 2025, at 11:52 a.m., clinical nurse supervisor (CNS)-D stated they were aware of the Statue that they needed to complete assessments within 90-days; and they may have just missed the late assessment. The licensee's Assessment Schedules policy dated November 1, 2022, indicated ongoing resident reassessment and monitoring would be completed based on changes in the needs of the resident but could not exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

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01640	Continued From page 71 (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 interview and record review, the licensee failed to ensure a current service plan was completed within fourteen days of starting services 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 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).	01640			

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01640	Continued From page 72 The findings include: R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster. However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's clinical record lacked an executed written contract with the required content. R2's Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication administration. The service plan was not signed by R2 or the licensee. On June 11, 2025, at 8:14 a.m., unlicensed personnel (ULP)-A stated they provided R2 assistance with meals, medications, laundry, and transportation. On June 12, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-D stated R2 had lived at the facility previously but then had moved to Chicago. CNS-D stated R3 came back a few weeks ago and was coming and going. CNS-D confirmed R2 did not have a signed service agreement. CNS-D stated R2's service plan was not completed as the assessment had not been completed since they thought they had five days to complete. The licensee's Service Plan policy dated November 1, 2022, indicated all residents receiving assisted living services would have a service plan in place within 14 days after the date that services were first provided. No further information provided.	01640			

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01640	Continued From page 73	01640			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication	01700			

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01700	Continued From page 74 management assessment to include all required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster. However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication administration. The service plan was not signed by R2 or the licensee. R2's Med Admin Summary - Month (MAR) dated May 2025, indicated R2 had received assistance with medications May 23, 2025, through May 31, 2025. R2's Med Admin Summary - Month (MAR) dated June 2025, indicated R2 had received assistance with medications June 1, 2025, through June 8, 2025. R2's record lacked a completed medication assessment by a registered nurse.	01700			

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01700	Continued From page 75 On June 10, 2025, at 8:53 a.m., clinical nurse supervisor (CNS)-D stated staff were assisting R2 with medications however R2 self-administered their own medications. On June 10, 2025, at 9:13 a.m., CNS-D stated R2's medication portion was not completed on R2's assessment. On June 11, 2025, at 8:14 a.m., unlicensed personnel (ULP)-A stated they assisted R2 with medications. ULP-A stated R2 had medications locked in storage. ULP-A stated they gathered R2's medications after R2 ate breakfast and placed them in a cup for R2 to take the medications. On June 11, 2025, at 9:04 a.m., CNS-D stated R2 was still unpacking and trying to get their medications. CNS-D stated they still needed to complete the assessment which they thought they had a five-day window to do so. The licensee's Medication Management - Assessment, Monitoring & Reassessment policy dated November 1, 2022, indicated the licensee would, prior to providing medication management services, have an RN conduct an assessment to determine what medication management services would be provided and how the services would be provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan	01730			

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01730	Continued From page 76 (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730			

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01730	Continued From page 77 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster. However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication administration. The service plan was not signed by R2 or the licensee. R2's record lacked a completed medication	01730			

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01730	Continued From page 78 assessment by a registered nurse. R2's undated Individualized Medication Management Plan (IMMP) indicated staff were to assist with medication administration and medication self-administration was not applicable. R2's IMMP lacked the required content to include a description of storage; specific resident instructions related to the administration of medications; identification of persons responsible for monitoring medication supplies; identification of medication management tasks that may be delegated to unlicensed personnel (ULP); procedures for staff to notify a registered nurse or appropriate licensed health professional for any problems; and any resident specific requirements related to documentation of medication administration. On June 11, 2025, at 9:04 a.m., clinical nurse supervisor (CNS)-D stated R2 was still unpacking and trying to get their medications. CNS-D stated they still needed to complete the assessment which they thought they had a five-day window to do so. R3 On June 12, 2025, at 10:03 a.m., the surveyor observed ULP-B assist R3 with administration of R3's oral medications. R3 was admitted to the licensee on November 4, 2022, with diagnosis of hypertension. R3's Service Plan Form dated September 19, 2024, indicated R3 received assistance with medication administration. R3's assessment dated March 28, 2025, indicated R3 was deemed unable to safety	01730			

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01730	Continued From page 79 self-administer medications. R3's Med Admin Summary - Month dated June 2025, indicated R3 received assistance with oral medications and a subcutaneous injection medication from ULP-B every day from June 1, 2025, through June 11, 2025. R3's IMMP dated June 9, 2023, indicated medication management tasks that could be delegated to ULP's included topical, per neb, transdermal, inhaler, eye drops, ear drops, nasal, and sublingual medications. R3's IMMP lacked identification of medication management tasks that may be delegated to ULP's for R3's oral and subcutaneous injection medications. The licensee's undated Medication Management Individualized Plan policy indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the residents' assessment and would contain the following: description of storage; specific resident instructions related to the administration of medications; identification of persons responsible for monitoring medication supplies; identification of medication management tasks that may be delegated to unlicensed staff; procedures for staff to notify a registered nurse or appropriate licensed health professional for any problems; and any resident specific requirements related to documentation of medication administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

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01760	Continued From page 80	01760			
01760 SS=F	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 medication administration was documented accurately for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster.	01760			

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01760	Continued From page 81 However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication administration. The service plan was not signed by R2 or the licensee. R2's record lacked authenticated current prescription orders for all medications managed by licensee. R2's Med Admin Summary - Month (MAR) dated May 2025, indicated R2 had received assistance with medications May 23, 2025, through May 31, 2025; and included the following medications: Apixaban, docusate sodium, glipizide, losartan potassium, metformin, Ventolin, vitamin D, divalproex sodium, propranolol, quetiapine fumarate, trazodone, doxepin, simvastatin, and azelastine hydrochloride. R2's MAR lacked documentation of medication administration or reason why medication administration was not completed from May 23, 2025, through May 31, 2025, for the following scheduled medications: Apixaban, docusate sodium, glipizide, losartan potassium, metformin, Ventolin, vitamin D, and simvastatin. R2's Med Admin Summary - Month (MAR) dated June 2025, indicated R2 had received assistance with medications June 1, 2025, through June 8, 2025; and included the following medications: Apixaban, docusate sodium, glipizide, losartan potassium, metformin, Ventolin, vitamin D, divalproex sodium, propranolol, quetiapine fumarate, trazodone, doxepin, simvastatin, and azelastine hydrochloride. R2's MAR lacked	01760			

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NAME OF PROVIDER OR SUPPLIER CARING ANGELS		STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445			
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01760	Continued From page 82 documentation of medication administration or reason why medication administration was not completed from June 1, 2025, through June 8, 2025, for the following scheduled medications: Apixaban, docusate sodium, glipizide, losartan potassium, metformin, Ventolin, vitamin D, and simvastatin. R2's record lacked documentation any follow-up procedures that were provided to meet the resident's need when the medication was not administered as scheduled. On June 11, 2025, clinical nurse supervisor (CNS)-D stated R2 was in the licensee's electronic record as a potential resident, however staff had documented on medication administration even if the resident was not in the home. R3 R3 was admitted to the licensee on November 4, 2022, with diagnosis of hypertension. R3's Service Plan Form dated September 19, 2024, indicated R3 received assistance with medication administration. R3's record lacked authenticated current prescription orders for the following medications managed by the licensee: lisinopril; Jardiance; Lantus; and pantoprazole. R3's MAR dated May 2025, indicated R3 received assistance with medication administration for the following medications: Amlodipine besylate; atorvastatin; carvedilol; lisinopril; memantine; omeprazole; sertraline; vitamin B-1; Jardiance; Lantus; pantoprazole; mirtazapine; and trazodone. R3's MAR lacked documentation of	01760			

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01760	Continued From page 83 medication administration or reason why medication administration was not completed on May 8, 2025, for Jardiance, Lantus and pantoprazole; and on May 9, 2025, for Jardiance, Lantus, pantoprazole, carvedilol, mirtazapine, and trazodone. R3's record lacked documentation any follow-up procedures that were provided to meet the resident's need when the medication was not administered as scheduled. On June 11, 2025, at 9:26 a.m., the surveyor observed unlicensed personnel (ULP)-A administer R3's eye drops into both eyes. Following the observation of R3's eye drop administration, ULP-A stated they would document the administration of the eye drops after they provided R3 with breakfast and their oral medications. The surveyor did not observe ULP-A document the administration of R3 eye drops following the administration. Also, R3's MAR did not include a medication for eye drops. On June 12, 2025, at 10:03 a.m., the surveyor observed ULP-B compare medications that were preset-up by the pharmacy with R3's MAR. The medications in the preset-up package from the pharmacy included the following medications: amlodipine 10 milligrams (mg 0; atorvastatin 40 mg; carvedilol 12.5 mg; Jardiance 10 mg; lisinopril 10 mg; memantine 28 mg; pantoprazole 40 mg; sertraline 100 mg; and vitamin B 100 mg. The surveyor observed ULP-B enter a note in the licensee's electronic record for R3's MAR, "meds given upon wake up" and then checked a box to indicate all 8:00 a.m. medications were administered. The surveyor then observed ULP-B give the preset-up medications to R3 for medication administration after ULP-B had	01760			

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01760	Continued From page 84 documented all medications were administered. R3's MAR also included omeprazole which was not included in the preset-up package of medications from pharmacy. The surveyor did not observe omeprazole being administered to R3 however this medication was observed to be checked off on R3's MAR as being administered. On June 12, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-D stated they expected staff to document on all scheduled medications as either being administered or the reason why it was not administered. CNS-D stated they would provide further training to staff. The licensee's Medication Management - Administration & Set up policy dated November 1, 2022, indicated documentation of a medication assistance or medication administration would be completed immediately after a task was performed. Also, the policy indicated unlicensed personnel would document any reason why medication administration was not completed as prescribed; and document any follow-up procedures that were provided to meet the resident's need when the medication was not administered as prescribed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide	01790			

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01790	Continued From page 85 medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident,	01790			

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01790	Continued From page 86 and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures, training and competencies for the unlicensed personnel (ULP) who would provide medications to residents who had unplanned time away when the licensed nurse was not available for two of two unlicensed personnel ((ULP)-A, 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 potential to affect a large portion or all of the residents). The findings include:	01790			

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01790	Continued From page 87 ULP-A ULP-A was hired on April 19, 2023. On June 10, 2025, at 8:58 a.m., the surveyor observed ULP-A prepare R4's medications to be sent with R4 to be administered at the day program. ULP-A compared the oral medications that were preset up from the pharmacy in a bubble pack with the medication administration record (MAR). During the observation, R4 had walked into the kitchen area and asked for his medications as they stated their ride was there. The surveyor was not able to identify if all scheduled medications on the MAR, other than oral medications in the prefilled pack, were prepared for R4. ULP-A stated they would not document the medications as administered until they knew R4 took the medications as they would call the day center to confirm. ULP-A stated they would then document medications taken at daycare. ULP-A was observed leaving the facility with R4's oral medications in a prefilled pack from pharmacy as they stated they were going to tell the driver and give the medications to the driver to be delivered to the day care. ULP-A's personnel record lacked documentation of training and competency for ULP-A who would provide medications to residents who had unplanned time away when the licensed nurse was not available. ULP-B ULP-B was hired on February 5, 2023. On June 10, 2025, at 1:37 p.m., the surveyor observed ULP-B checking R4's blood glucose via Dexcom (continuous blood glucose monitor system).	01790			

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01790	Continued From page 88 ULP-B's personnel record lacked documentation of training and competency for ULP-B who would provide medications to residents who had unplanned time away when the licensed nurse was not available. On June 10, 2025, at 11:18 a.m., the surveyor asked clinical nurse supervisor (CNS)-D if they had a specific written procedure for residents who had a planned or unplanned time away. CNS-D was observed looking thru the licensee's policy binder; and provided a blank competency form for planned and unplanned times away to the surveyor. CNS-D stated they had found the policy, but it indicated the nurse had to develop written procedures. CNS-D stated they had not created the procedure as it was the first time the resident needed to take medications with them. On June 12, 2025, at 11:02 a.m., CNS-D stated they had not provided any training to ULPs on planned or unplanned time away for medications. The licensee's undated Medication Management - Planned & Unplanned Time Away policy indicated for unplanned time away, a licensed nurse or properly trained and competency tested ULP may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence following specific requirements. Also, the policy indicated the registered nurse could only delegate the task to ULP if the nurse had trained the ULP and determined the ULP to be competent; and the registered nurse had developed written procedures for the ULP No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01790			

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01790	Continued From page 89	01790			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were maintained for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster. However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication	01820			

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01820	Continued From page 90 administration. The service plan was not signed by R2 or the licensee. R2's Med Admin Summary - Month (MAR) dated May 2025, indicated R2 had received assistance with medications May 23, 2025, through May 31, 2025. R2's Med Admin Summary - Month (MAR) dated June 2025, indicated R2 had received assistance with medications June 1, 2025, through June 8, 2025. R2's record lacked authenticated current prescription orders for all medications managed by licensee. On June 11, 2025, at 12:31 p.m., clinical nurse supervisor (CNS)-D stated the licensee did not have any written or electronically recorded prescriptions for R2 as they were in the process of trying to have R2's provider fax orders. R3 R3 was admitted to the licensee on November 4, 2022, with diagnosis of hypertension. R3's Service Plan Form dated September 19, 2024, indicated R3 received assistance with medication administration. R3's MAR dated June 2025, indicated R3 received assistance with medication administration for the following medications: Amlodipine besylate; atorvastatin; carvedilol; lisinopril; memantine; omeprazole; sertraline; vitamin B-1; Jardiance; Lantus; pantoprazole; mirtazapine; and trazodone. R3's record lacked authenticated current	01820			

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01820	Continued From page 91 prescription orders for the following medications managed by the licensee: lisinopril; Jardiance; Lantus; and pantoprazole. On June 12, 2025, at 12:55 p.m., CNS-D stated R3 should have had orders. The licensee's Medication & Treatment Orders policy dated November 1, 2022, indicated the RN is responsible for assuring current, authorized prescriber orders for medications administered by the staff are kept on file in the residents' records. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
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 all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. The deficient practice 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	01880			

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01880	Continued From page 92 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 the residents). The findings include: R2 On June 9, 2025, at 1:14 p.m., during a tour of the facility, the surveyor observed R2's room had unsecured medications that included the following: Olopatadine, Systane, Tribulus terrestris extract, and a plastic bag with unknown medications. R2 was admitted to the licensee on June 7, 2025, per the licensee's current resident roster. However, R2's clinical record indicated documentation of services dated back to May 23, 2025. R2's Service Plan (private) - Addendum to Contract dated May 28, 2025, indicated R2 received assistance with medication administration. The service plan was not signed by R2 or the licensee. R2's undated Individualized Medication Management Plan indicated staff were to assist with medication administration and medication self-administration was not applicable. R2's record lacked a completed medication assessment by a registered nurse. On June 9, 2025, at 1:17 p.m., clinical nurse supervisor (CNS)-D stated they expected R2's medications to be locked in the medication room. CNS-D stated R2's medications were all locked	01880			

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01880	Continued From page 93 the last time they were at the facility; and they would remove the medications from R2's room to lock up the unsecured medications. R3 On June 9, 2025, at 1:00 p.m., during a tour of the facility, the surveyor observed R3's eye drops sitting on a table next to R3 in the common living room area without staff being present. R3 stated the eye drops were theirs and they put eye drops in their eyes themself. R3 was admitted to the licensee on November 4, 2022, with diagnosis of hypertension. R3's Service Plan Form dated September 19, 2024, indicated R3 received assistance with medication administration. R3's assessment dated March 28, 2025, indicated R3 required assistance from staff to administer medications. The assessment lacked an assessment of R3's ability to self-manage medications. R3's Individualized Medication Management Plan completed on June 9, 2023, indicated R3's medications were to be administered by staff and would be stored in a locked cabinet. On June 12, 2025, at 10:42 a.m., CNS-D stated all medications at this facility should be stored securely and locked since all residents required assistance with medication. The licensee's Medication Storage policy dated November 1, 2022, indicated medications managed and stored by the licensee would be kept securely locked and stored per manufacturer's directions. Also, the policy	01880			

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01880	Continued From page 94 indicated only authorized staff would have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of	01910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER CARING ANGELS			STREET ADDRESS, CITY, STATE, ZIP CODE 9130 LOUISIANA AVENUE NORTH BROOKLYN PARK, MN 55445		
(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
01910	Continued From page 95 medications 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on October 23, 2023, with diagnoses of Parkinson's disease, arthritis, chronic back pain, and spinal stenosis. R1's Service Plan (Waiver) - Addendum to contract dated May 28, 2025, indicated R1 received assistance with medication administration. R1's Assessment dated January 12, 2024, indicated R1 needed full medication management and set up. R1's Discharge/Transfer Summary dated June 9, 2025, indicated R1 was discharged on February 12, 2024, to an assisted living facility in Brooklyn Park. R1's record lacked a disposition of medications to include 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.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2025
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01910	Continued From page 96 On June 10, 2025, at 10:21 a.m., clinical nurse supervisor (CNS)-D stated the licensee had a discharge summary but did not have a medication disposition for R1. CNS-D stated R1 was discharged with a medication list and the medications were given to R1 and R1's power of attorney. CNS-D stated the licensee would normally document the medication disposition on the discharge summary; however, they did not know why this was not documented on R1's discharge summary. CNS-D stated they did not know a medication disposition included the documentation of the medication quantity and names of staff and other individuals involved in the disposition of medications. The licensee's Medication Disposal policy dated November 1, 2022, indicated upon disposition, the licensee must document in the residents record the disposition of the medication to include the medication name, strength, prescription number, quantity, to whom the medications were given, date of disposition, and the names of staff and other individuals involved in the disposition. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Caring Angels
9130 Louisiana Avenue N
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 38746

Risk:
License:
Expires on:
CFPM: Milgo A. Sharif
CFPM #: 115944; Exp: 02/24/2026

Inspection Info

Report Number: F1051251033
Inspection Type: Full - Single
Date: 6/9/2025 Time: 11:00:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 Priority Level: Priority 1 CFP#: 22

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT:

AT THE TIME OF THE INSPECTION, THE CUT TOMATOES MEASURED 46 DEG F & MILK MEASURED 45 DEG F IN THE TOP SECTION OF THE UPRIGHT COOLER. TURN UNIT COOLER.

Comply By: 6/9/2025 Originally Issued On: 6/9/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B Priority Level: Priority 2 CFP#: 36

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT:

AT THE TIME OF THE INSPECTION, THERE IS NO THIN-TIPPED THERMOMETER.

Comply By: 6/13/2025 Originally Issued On: 6/9/2025

Food & Beverage General Comment

MET WITH NURSE EVALUATOR, RHAWNIE QUINEHAN.

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, NADIA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HANDWASHING & GLOVE USE

THE KITCHEN HAS A SMOOTH TEXTURE CEILING, LAMINATE CABINETS, STONE COUNTERTOPS WITH HOLLOW BASES, A NSF 184 DISHWASHER, AND VINYL FLOORS.

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

I acknowledge receipt of the St Cloud District Office inspection report number F1051251033 from 6/9/2025

Nadia

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Caring Angels
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1051251033
Inspection Type: Full
Date: 6/9/2025
Time: 11:00:00 AM

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

Location: Upright Cooler at 46 Degrees F.

Comment: TOP SECTION

Violation Issued?: Yes

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

Location: Upright Cooler at 45 Degrees F.

Comment: TOP SECTION

Violation Issued?: Yes

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

Location: Upright Cooler at 41 Degrees F.

Comment: CENTER DRAWER

Violation Issued?: No