



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 28, 2026

Licensee

Genesis Assisted Living LLC
1019 South Madison Street
Shakopee, MN 55379

RE: Project Number(s) SL39771016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2026, 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:

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

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$1,000.00

1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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 that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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: SL39771016-0 On July 27, 2026 through July 30, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five resident(s); all of whom were receiving services under the Assisted Living Facility license. An immediate correction order was identified on July 28, 2026, issued for SL39771016-0, tag identification 1750. An immediate correction order was identified on July 29, 2026, issued for SL39771016-0, tag identification 1950. During the course of the survey, the licensee took action to mitigate the imminent risk.	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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	Continued From page 1	0 000			
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 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 ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares and medication administration for one of two employees (unlicensed personnel (ULP)-D). This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 510	Continued From page 2 a large portion or all of the residents). The findings include: During the entrance conference on July 27, 2026, at 10:54 a.m., owner/licensed assisted living director (O/LALD)-A stated the licensee provided medication management and assistance with ADLs (activities of daily living) to residents at the facility. ULP-D's Educare (online training platform) Transcript indicated ULP-D completed Medication Administration- Overview on May 26, 2026. In addition, ULP-D's record indicated ULP-D completed Medication Administration- Routes and Medication Administration- Insulin Pen on May 27, 2026. ULP-D's Educare Transcript lacked evidence which indicated ULP-D completed infection control training. On July 27, 2026, at 12:31 p.m., the surveyor observed ULP-D complete scheduled insulin administration for R2. Without performing hand hygiene, ULP-D applied gloves, removed the insulin pen cap and applied the needle without scrubbing the top of the insulin pen, administered five units of insulin, removed gloves, removed and disposed of the needle with ungloved hands, and completed hand hygiene. The surveyor did not observe ULP-D complete hand hygiene before medication administration, clean the top of the insulin pen before application of the needle, or handle used sharps with gloved hands. On July 26, 2026, at 12:45 p.m., the surveyor observed ULP-D complete medication administration for R3. Without performing hand hygiene, at 1:02 p.m., ULP-D applied new gloves and completed medication preparation for R5.	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 510	Continued From page 3 With gloved hands, ULP-D carried R5's medications from the nursing office to R5's room, knocked on the door and opened the door touching the exterior door handle. Without changing gloves, ULP-D administered oral medications to R5 and applied diclofenac gel (pain reliever) to R5's knees, bilaterally. On July 28, 2026, at 7:11 a.m., the surveyor observed ULP-D complete medication administration and treatment for R4. ULP-D completed hand hygiene, applied gloves, and administered oral medications. Without performing hand hygiene, ULP-D changed gloves and washed R4's tracheostomy stoma (exterior opening on the throat for breathing). Without performing hand hygiene or changing gloves, ULP-D applied Aquaphor to the cleaned stoma site, washed R4's face, and applied ketoconazole (antifungal face cream) 2% to R4's face followed by application of diclofenac gel (pain reliever) to R4's left shoulder. Without performing hand hygiene, ULP-D changed gloves, combed R4's hair, set up R4's scheduled nebulizer treatment, and refilled R4's tracheostomy humidifier gravity bag with distilled water before removing gloves and performing hand hygiene. On July 28, 2026, at 9:03 a.m., ULP-D stated hand hygiene was supposed to be completed before each resident's medication administration and after removing gloves. ULP-D further stated gloves were worn during resident cares and treatments and changed when dirty or at the end of cares. ULP-D stated ULP-D realized ULP-D missed changing gloves and completing hand hygiene and ULP-D needed to slow down to avoid missing steps for infection control. On July 29, 2026, at 9:42 a.m., registered nurse	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 510	Continued From page 4 consultant (RNC)-F stated hand hygiene was to be completed before and after each resident interaction, between all tasks, and with glove changes. RNC-F further stated gloves were to be worn when administering insulin, when resident treatments were performed, and when food was handled. RNC-F stated gloves were to be changed when going from dirty to clean tasks. The licensee's Medication and Treatment Insulin Pen competency procedure indicated after removal of an insulin pen cover, the tip was cleaned with an alcohol swab prior to application of a needle. The licensee's Infection Control policy dated January 1, 2023, indicated infection control practices of employees conformed with OSHA (Occupational Safety Hazards Association) regulations, current law and currently accepted health care, medical and nursing standards of practice. The policy further indicated hands were washed if contaminated, immediately after gloves were removed, between resident contacts, and when indicated to prevent transfer of microorganisms between a resident and the environment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 5 records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for three of three employees (owner/licensed assisted living director (O/LALD)-A, unlicensed personnel (ULP)-D, and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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).	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 6 The findings include: During the entrance conference on July 27, 2026, at 11:16 a.m., O/LALD-A stated the licensee was aware of required contents in an employee record. At 11:17 a.m., registered nurse (RN)-C indicated newly hired employees completed knowledge training through EduCare (online training platform), skills training with RN-C or clinical nurse supervisor (CNS)-B, and demonstrated competency to CNS-B or RN-C before working with residents independently. O/LALD-A O/LALD-A was hired on March 2, 2023, to provide direct care services to residents and leadership to employees of the licensee. ULP-D ULP-D was hired May 21, 2026, to provide direct care services to residents. On July 28, 2026, at 12:30 p.m., surveyor observed ULP-D provide R2's Novolog insulin pen and needle to R2's sister who had arrived to take R2 on an outing over the next scheduled mealtime. ULP-E ULP-E was hired July 14, 2026, to provide direct care services to residents. On July 27, 2026, at 3:47 p.m., surveyor observed ULP-E assist R5 to transfer onto the resident's recumbent bike. R2's Resident Notes- One Resident (progress notes) dated July 1, 2026, through July 27, 2026, indicated on July 18, 2026, from 11:30 a.m. to 8:00 p.m., and July 24, 2026, from 8:30 a.m. to	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 7 6:05 p.m., R2 was on leave of absences with family over time which R2 had scheduled medication including Novolog. Employee records for the above employees all lacked evidence of competency to prepare medication for administration during a resident's unplanned time away. On July 29, 2026, at 12:38 p.m., ULP-D stated ULP-D completed leave of absence medication set-up training and competency testing with a nurse and ULP-D contacted the nurse if there were ever any questions about the process. On July 29, 2026, at 12:40 p.m., O/LALD-A stated all staff completed leave of absence medication set-up training and competency testing with an RN however the training was not documented. The licensee's Medication Management Plan for Residents Away from Home policy dated January 1, 2023, indicated a ULP was able to provide medication(s) for a resident's leave of absence (LOA) after demonstration of competency for the designated procedures. The licensee's undated Resident out of Facility Family Notification policy indicated a list of medication(s) a resident was scheduled to receive while on a leave of absence (LOA) would be provided along with the medication supply. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 8 orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 9 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of TB training at the time of hire for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 27, 2026, at 10:49 a.m., owner/licensed assisted living director (O/LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 10 MDH was completed on July 15, 2026, and the facility was determined to be a low risk level. ULP-E was hired July 14, 2026, to provide direct care services to residents. On July 27, 2026, at 3:47 p.m., the surveyor observed ULP-E assist R5 to transfer onto the resident's recumbent bike. ULP-E's employee record lacked evidence of completion of TB training at the time of hire. On July 28, 2026, at 10:37 a.m., O/LALD-A stated, "You are going to see we are missing some training and education courses for employees. We have had such high turnover that it was hard to keep up with orientation and training." The licensee's TB Screening/Prevention policy dated January 1, 2023, indicated all employees who provided care to residents received TB education when hired and annually. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 11 (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: Based on interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the provisional assisted living license.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 680	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked the following required content: - maintain and annual EPP updates; - names and contact information; - emergency officials contact information; - EPP training program; and - emergency prep testing requirements. On July 29, 2026, at 11:28 a.m., licensed assisted living director (LALD)-A stated the licensee's missing resident policy was reviewed by the nurse every six months and documentation which supported the policy review was not completed. LALD-A further stated LALD-A believed LALD-A confused the missing resident policy review schedule with another regulation requirement which cause the frequency of review to be out of compliance. LALD-A stated missing contact information was believed to be present, however LALD-A acknowledged it was not present and that it was missed in error. LALD-A further stated LALD-A was aware that two disaster drills were required to be completed annually and that the licensee needed to conduct more drills to be compliant. LALD-A stated a tornado drill was completed in February 2026 however there was no documentation to support the drill being	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(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
0 680	Continued From page 13 conducted and LALD-A was unsure when the most recent disaster drill was completed prior to February 2026. The licensee's Emergency Preparedness policy dated January 1, 2023, indicated the licensee provided emergency preparedness education to staff upon hire and annually. The policy further indicated a disaster drill was conducted and documented annually. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 775	Continued From page 14 environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 7-29-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 810	Continued From page 15 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 810	Continued From page 16 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 7-29-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for three of three residents (R2, R3, and R4). This had the potential to affect all residents who received assisted living services. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 910	Continued From page 17 the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 27, 2026, at 10:49 a.m., owner/ licensed assisted living director (O/LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2 was admitted to the licensee and began receiving assisted living services on December 15, 2025. R2's [licensee] Summary of Important Terms (contract) was signed on December 15, 2025. On July 27, 2026, at 12:31 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled medication. R3 R3 was admitted to the licensee and began receiving assisted living services on November 13, 2023. R3's [licensee] Summary of Important Terms (contract) was signed on November 13, 2023. On July 27, 2026, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's scheduled medication. R4 R4 was admitted to the licensee and began	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
0 910	Continued From page 18 receiving assisted living services on July 24, 2025. R4's [licensee] Summary of Important Terms (contract) was signed on July 24, 2025. On July 28, 2026, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R4's scheduled medication. R2, R3 and R4's assisted living contracts lacked the licensee's healthcare facility identification number (HFID). On July 27, 2026, at 1:18 p.m., O/LALD-A stated all residents signed the same contract version. O/LALD-A further stated the licensee's HFID was missing on all contracts due to O/LALD-A's misunderstanding of which number was required to be included on the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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 19 (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (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 competency was completed for three of three employees (owner/licensed assisted living director (O/LALD)-A, unlicensed personnel (ULP)-C and ULP-D) to include all required content. This practice resulted in a level two violation (a	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(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 20 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 27, 2026, at 11:16 a.m., O/LALD-A stated the licensee was aware of required contents in an employee record. At 11:17 a.m., registered nurse (RN)-C stated newly hired employees completed knowledge training through EduCare (online training platform), skills training with RN-B or clinical nurse supervisor (CNS)-B, and demonstrated competency to CNS-B or RN-C before working with residents independently. O/LALD-A O/LALD-A was hired on March 2, 2023, to provide direct care services to residents and leadership to licensee employees. O/LALD-A's employee record lacked evidence of training for the following topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; and - awareness of confidentiality and privacy. ULP-D ULP-D was hired May 21, 2026, to provide direct	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(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 21 care services to residents. On July 27, 2026, at 12:31 p.m., the surveyor observed ULP-D administer scheduled medication to R2. ULP-D's employee record lacked evidence of training for the following topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - 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; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; and - standby assistance techniques and how to perform them. ULP-D's record lacked evidence of competency having been demonstrated for the following: - standby assistance techniques and how to perform them. ULP-E ULP-E was hired July 14, 2026, to provide direct care services to residents. On July 27, 2026, at 3:47 p.m., the surveyor observed ULP-E assist R5 to transfer onto the resident's recumbent bike. ULP-E's employee record lacked evidence of training for the following topics:	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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 22 - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - 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; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; and - standby assistance techniques and how to perform them. - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. ULP-E's record lacked evidence of competency having been demonstrated for the following: - appropriate and safe techniques in personal hygiene and grooming, including:	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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 23 - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; and -standby assistance techniques and how to perform them. On July 28, 2026, at 9:03 a.m., ULP-D stated ULP-D completed training modules issued through Educare and job shadowing to learn tasks hands-on. ULP-D further stated ULP-D could not recall completing competency testing with a registered nurse (RN) prior to working independently. On July 28, 2026, at 10:37 a.m., O/LALD-A stated, "You are going to see we are missing some training and education courses for employees. We have had such high turnover that it was hard to keep up with orientation and training." On July 28, 2026, at 4:12 p.m., O/LALD-A stated O/LALD-A's employee file was missing the above missing training topics due to the required modules not being issued in error. The licensee's Staff Orientation and Education policy dated January 12, 2025, indicated upon hire and before services were provided to residents, all employees attended general orientation and those providing direct care services completed competency evaluations as part of the orientation process. The policy further indicated [licensee] maintained proof of orientation and education in the employee files. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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 24 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01380	Continued From page 25 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 training and competency was completed for two of three employees (unlicensed personnel (ULP)-C and ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 27, 2026, at 11:16 a.m., O/LALD-A stated the licensee was aware of required contents in an employee record. At 11:17 a.m., registered nurse (RN)-C stated newly hired employees completed knowledge training through EduCare (online	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01380	Continued From page 26 training platform), skills training with RN-B or clinical nurse supervisor (CNS)-B, and demonstrated competency to CNS-B or RN-C before working with residents independently. O/LALD-A O/LALD-A was hired on March 2, 2023, to provide direct care services to residents and leadership to licensee employees. O/LALD-A's employee record lacked evidence of training for the following topics: - observation, reporting, and documenting of resident status; and - safe transfer techniques and ambulation. O/LALD-A's employee record lacked evidence of competency having been demonstrated for the following: - range of motioning and positioning; and - stoma care. ULP-D ULP-D was hired May 21, 2026, to provide direct care services to residents. On July 27, 2026, at 12:31 p.m., the surveyor observed ULP-D administer scheduled medication to R2. ULP-D's employee record lacked evidence of training for the following topics: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident;	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01380	Continued From page 27 - safe transfer techniques and ambulation; and - range of motioning and positioning. ULP-D's employee record lacked evidence of competency having been demonstrated for the following: - stoma care. ULP-E ULP-E was hired July 14, 2026, to provide direct care services to residents. On July 27, 2026, at 3:47 p.m., the surveyor observed ULP-E assist R5 to transfer onto the resident's recumbent bike. ULP-E's employee record lacked evidence of training for the following topics: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. ULP-E's employee record lacked evidence of competency having been demonstrated for the following: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; - monitoring vital signs; and - stoma care.	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01380	Continued From page 28 On July 28, 2026, at 9:03 a.m., ULP-D stated ULP-D completed training modules issued through Educare and job shadowing to learn tasks hands-on. ULP-D further stated ULP-D could not recall completing competency testing with a registered nurse (RN) prior to working independently. On July 28, 2026, at 10:37 a.m., O/LALD-A stated, "You are going to see we are missing some training and education courses for employees. We have had such high turnover that it was hard to keep up with orientation and training." On July 28, 2026, at 4:12 p.m., O/LALD-A stated O/LALD-A's employee file was missing the above missing training topics due to the required modules not being issued in error. The licensee's Staff Orientation and Education policy dated January 12, 2025, indicated upon hire and before services were provided to residents, all employees attended general orientation and those providing direct care services completed competency evaluations as part of the orientation process. The policy further indicated [licensee] maintained proof of orientation and education in the employee files. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number;	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01380	Continued From page 29 (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 30 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 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 one of three employees (unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame. In addition, the licensee failed to ensure one of three employees received the required amount of annual dementia care training.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a client'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: The licensee held an assisted living license effective March 2, 2026. During the entrance conference on July 27, 2026, at 10:55 a.m., owner/licensed assisted living director (O/LALD)-A stated the licensee was aware of the required contents of the employee records. ULP-D was hired May 21, 2026, to provide direct care services to residents. On July 27, 2026, at 12:31 p.m., the surveyor observed ULP-D administer scheduled medication to R2. ULP-D's Timecard Report dated May 6, 2026, through July 5, 2026, indicated as of June 25, 2026, ULP-D worked 166 hours and 30 minutes for [licensee]. ULP-D's record included ULP-D's Educare (online training platform) transcript of training completed with dates ranging from May 20, 2026, through May 31, 2026, which indicated ULP-D completed six hours of dementia care training.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 32 On July 28, 2026, at 10:51 a.m., O/LALD-A stated ULP-D lacked the required number of hours of dementia training due to O/LALD-A not issuing the correct number of hours of training modules in error. The licensee's Dementia Education policy dated January 1, 2023, indicated direct care employees were required to complete eight hours of initial dementia training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 33 be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing comprehensive nursing assessments for two of three residents (R2 and R3). In addition, the licensee failed to ensure the RN completed ongoing comprehensive nursing assessments not to exceed every 90 days for one of three	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 34 residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 27, 2026, at 10:56 a.m., RN-C stated a RN completed a comprehensive preadmission assessment, admission assessment, 14 days after admission, and then at least every 90 days unless the resident had a change of condition or hospitalization. ASSESSMENTS COMPLETED BY LICENSED PRACTICAL NURSE (LPN) R2 R2 was admitted to the licensee on December 15, 2025. R2's diagnoses included bipolar disorder (mental health condition causing extreme shifts in mood, energy and activity levels and emotional highs and lows), diabetes, hypertension (elevated blood pressure), and Chronic Obstructive Pulmonary Disease (COPD-lung disease causing restricted airflow and breathing difficulties). R2's Service Plan- Modification dated December 15, 2025, indicated R2's services included dressing, bathing and grooming, medication	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 35 administration four times per day, blood glucose monitoring four times per day, meals, housekeeping, laundry and linens, and daily safety check. On July 27, 2026, at 12:31 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled medication. R2's record included 90-day Assessments dated February 6, 2026, and May 15, 2026, respectively, completed by clinical nurse supervisor (CNS)-B. R2's record also included a Change in Condition Assessment dated July 9, 2026, completed by LPN-G. R2's record lacked evidence of a change of condition assessment completed by an RN. R3 R3 was admitted to the licensee on November 13, 2023. R3's diagnoses included COPD, hypertension, diabetes, generalized anxiety disorder, asthma (lung disease that inflames and narrows the airways causing breathing challenges), and lymphedema (chronic swelling caused by blockage or damage in the lymphatic system). R3's Service Plan- Modification dated October 24, 2025, indicated R3's services included dressing, bathing and grooming, medication administration five times per day, blood glucose monitoring four times per day, behavior management, meals, housekeeping, laundry and linens, and safety checks six times per day.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 36 On July 27, 2026, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's scheduled medication. R3's record included a Change of Condition Assessment dated February 17, 2026, completed by an RN. R3's record also included a Change of Condition Assessment dated April 21, 2026, completed by LPN-H, and a Change of Condition Assessment dated July 9, 2026, completed by LPN-G. R3's record lacked evidence of change of condition assessments completed by an RN. LATE ASSESSMENTS R4 R4 was admitted to the licensee on July 24, 2025. R4's diagnoses included chronic respiratory failure (lungs are unable to move oxygen into the blood or remove carbon dioxide), hypertension, Major Depressive Disorder, pulmonary emphysema (damaged or destroyed air sacs in the lungs making it difficult to breath out), and protein-calorie malnutrition (combination of inadequate intake of protein and calories, malabsorption of nutrients, and increased energy expenditure). R4's Service Plan- Modification dated August 12, 2025, indicated R4's services included dressing, bathing and grooming, medication administration three times per day, laryngectomy humidification daily, behavior management, meals, housekeeping, laundry and linens, and safety checks five times per day.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 37 On July 28, 2026, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R4's scheduled medication. R4's record included 90-day Assessments completed by RN-C and clinical nurse supervisor (CNS)-B respectively, on November 8, 2025, and February 6, 2026. R4's record also included a 90-day Assessment completed by CNS-B on May 15, 2026, which indicated 98 days had passed since R4's previous comprehensive nursing assessment. R4's record lacked evidence of a 90-day reassessment completed by an RN in the required time frame. On July 30, 2026, at 1:03 p.m., CNS-B stated comprehensive nursing assessments were required to be completed within 90-days of the previous assessment or with a change of condition. CNS-B further stated LPN-G contacted CNS-B when LPN-G was completing assessments however CNS-B was not on-site or face-to-face. CNS-B stated CNS-B was unsure why R4's most recent assessment was completed late. On July 30, 2026, at 1:11 p.m., RN-C stated RN-C knew an LPN was able to complete data collection however, RN-C was unaware an LPN could not complete the comprehensive nursing assessments. The licensee's Assessment and Reassessment policy dated January 1, 2023, indicated ongoing resident assessments must be conducted by an RN and could not exceed 90 days from the last date of assessment.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 38 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01650	Continued From page 39 by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R2, R3, and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic 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 December 15, 2025. R2's diagnoses included bipolar disorder (mental health condition causing extreme shifts in mood, energy and activity levels and emotional highs and lows), diabetes, hypertension (elevated blood pressure), and Chronic Obstructive Pulmonary Disease (COPD-lung disease causing restricted airflow and breathing difficulties). R2's Service Plan- Modification dated December 15, 2025, indicated R2's services included dressing, bathing and grooming, medication administration four times per day, blood glucose monitoring four times per day, meals, housekeeping, laundry and linens, and daily safety check. On July 27, 2026, at 12:31 p.m., the surveyor observed unlicensed personnel (ULP)-D	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01650	Continued From page 40 administer R2's scheduled medication. R3 R3 was admitted to the licensee on November 13, 2023. R3's diagnoses included COPD, hypertension, diabetes, generalized anxiety disorder, asthma (lung disease that inflames and narrows the airways causing breathing challenges), and lymphedema (chronic swelling caused by blockage or damage in the lymphatic system). R3's Service Plan- Modification dated October 24, 2025, indicated R3's services included dressing, bathing and grooming, medication administration five times per day, blood glucose monitoring four times per day, behavior management, meals, housekeeping, laundry and linens, and safety checks six times per day. On July 27, 2026, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's scheduled medication. R4 R4 was admitted to the licensee on July 24, 2025. R4's diagnoses included chronic respiratory failure (lungs are unable to move oxygen into the blood or remove carbon dioxide), hypertension, Major Depressive Disorder, pulmonary emphysema (damaged or destroyed air sacs in the lungs making it difficult to breath out), and protein-calorie malnutrition (combination of inadequate intake of protein and calories, malabsorption of nutrients, and increased energy expenditure). R4's Service Plan- Modification dated August 12,	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01650	Continued From page 41 2025, indicated R4's services included dressing, bathing and grooming, medication administration three times per day, laryngectomy humidification daily, behavior management, meals, housekeeping, laundry and linens, and safety checks five times per day. On July 28, 2026, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R4's scheduled medication. R2, R3, and R4's service plans lacked the following content: - schedule and methods of monitoring assessments of the resident; - schedule and methods of monitoring staff providing services; and - a contingency plan which included: - the action taken if the scheduled service cannot be provided; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On July 30, 2026, at 1:16 p.m., registered nurse (RN)-C stated resident service plans included services provided to the resident including medications and treatments and required a resident or guardian signature. RN-C further stated RN-C was aware of the assessment frequency needing to be included in the service plan and acknowledged it was missing. On July 30, 2026, at 1:23 p.m., owner/licensed assisted living director (O/LALD)-A stated O/LALD-A was aware of the required content on resident service plans. O/LALD-A further stated the above missing content was missed in error.	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(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
01650	Continued From page 42 The licensee's Service Plan policy dated January 1, 2023, indicated resident service plans included the schedule and methods of monitoring reviews or assessments of the resident, the schedule and method of monitoring staff who provided the services, and a contingency plan which included the action(s) taken if the scheduled service was unable to be provided and circumstances in which emergency medical services were not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01700 SS=E	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	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01700	Continued From page 43 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 observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment to determine what medication management services would be provided and how the services would be provided, for two of three residents (R2 and R3). In addition the licensee failed to ensure the individualized medication assessment addressed self-storage of inhaled medications 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 27, 2026, at 10:25 a.m., owner/licensed assisted living director (O/LALD)-A stated the licensee provided	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01700	Continued From page 44 medication management services to the licensee's residents. MEDICATION MANAGEMENT ASSESSMENT COMPLETED BY LICENSED PRACTICAL NURSE (LPN) R2 R2 was admitted to the licensee on December 15, 2025. R2's diagnoses included bipolar disorder (mental health condition causing extreme shifts in mood, energy and activity levels and emotional highs and lows), diabetes, hypertension (elevated blood pressure), and Chronic Obstructive Pulmonary Disease (COPD-lung disease causing restricted airflow and breathing difficulties). R2's Service Plan- Modification dated December 15, 2025, indicated R2's services included dressing, bathing and grooming, medication administration four times per day, blood glucose monitoring four times per day, meals, housekeeping, laundry and linens, and daily safety check. On July 27, 2026, at 12:31 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled medication. R2's Individualized Medication Management Plan (IMMP) dated July 9, 2026, was completed by LPN-G, because of R2's change of condition and indicated R2 self-administers insulin injection after set-up by licensee employee. R2's record lacked a current Individualized Medication Management Plan (IMMP), completed by a RN.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01700	Continued From page 45 R3 R3 was admitted to the licensee on November 13, 2023. R3's diagnoses included COPD, hypertension, diabetes, generalized anxiety disorder, asthma (lung disease that inflames and narrows the airways causing breathing challenges), and lymphedema (chronic swelling caused by blockage or damage in the lymphatic system). R3's Service Plan- Modification dated October 24, 2025, indicated R3's services included dressing, bathing and grooming, medication administration five times per day, blood glucose monitoring four times per day, behavior management, meals, housekeeping, laundry and linens, and safety checks six times per day. On July 27, 2026, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's scheduled medication. During this observation, the surveyor observed R3's albuterol (treats wheezing and shortness of breath through rapid airway opening) inhaler on R3's walker seat and an opened box of ipratropium/albuterol (opens up air passages to treat breathing problems and wheezing) nebulizer vials on R3's tray table. R3's Med (medication) Admin (administration) Summary- Month dated July 1, 2026, through July 31, 2026, indicated R3's albuterol inhaler and ipratropium/albuterol nebulizer vials were administered by R3 independently and staff supervised the medication. R3's Individualized Medication Management Plan (IMMP) dated July 9, 2026, was completed by	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01700	Continued From page 46 LPN-G, because of R3's change of condition. In addition, R3's IMMP indicated R3 was able to safely administer inhalant medications. STORAGE OF MEDICATION R3's IMMP dated July 9, 2026, indicated all of R3's medications were stored in a locked area per facility protocol and lacked addressing storage of R3's ipratropium/albuterol vials. R3's record lacked a current IMMP completed by a RN and reflected self-storage of ipratropium/albuterol nebulizer vials. On July 27, 2026, at 12:56 p.m., R3 stated R3 used the inhaler independently, as needed, for shortness of breath. R3 further stated R3 stored R3's nebulizer solution in R3's room in order to self-administered R3's nebulizers at night when needed acutely. On July 27, 2026, at 12:58 p.m., unlicensed personnel (ULP)-D stated R3 independently administered R3's inhaler and nebulizer medications and notified staff if assistance was needed. On July 29, 2026, at 9:44 a.m., registered nurse consultant (RNC)-F stated medication management assessments and plans must be completed by a RN. The licensee's undated Medication Management Program policy indicated admission to the medication management program was at the discretion of the RN and based on a professional face-to-face nursing assessment. The licensee's Coordination in the Medication	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01700	Continued From page 47 Management Program policy dated January 1, 2023, indicated when an employee of the licensee became aware of a medication or supplement being used by a resident that was not included in the current medication management plan, the employee advised the RN of the change. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to reassess a resident for appropriate medication management services when resident's status changed for one of three residents (R4) who received medication management 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	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01710	Continued From page 48 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 27, 2026, at 10:25 a.m., owner/licensed assisted living director (O/LALD)-A stated the licensee provided medication management services to the licensee's residents. R4 was admitted to the licensee on July 24, 2025. R4's diagnoses included chronic respiratory failure (lungs are unable to move oxygen into the blood or remove carbon dioxide), hypertension, Major Depressive Disorder, pulmonary emphysema (damaged or destroyed air sacs in the lungs making it difficult to breath out), and protein-calorie malnutrition (combination of inadequate intake of protein and calories, malabsorption of nutrients, and increased energy expenditure). R4's Service Plan- Modification dated August 12, 2025, indicated R4's received medication administration services three times per day. R4's Med (medication) Admin (administration) Summary (EMAR)- Month dated July 1, 2026, through July 31, 2026, indicated R4 self-administered sildenafil 75mg once daily, as needed. R4's record included an order dated March 3, 2026, for sildenafil citrate 75 milligrams (mg) daily (increases blood flow to the penis), as needed.	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01710	Continued From page 49 R4's record also included an order dated September 2, 2025, which indicated R4 was approved to keep R4's sildenafil at bedside for as needed usage. On July 28, 2026, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R4's scheduled medication. During the medication administration observation, the surveyor observed an open bottle of R4's sildenafil on R4's nightstand. On July 28, 2026, at 7:24 a.m., R4 acknowledged the sildenafil was self-administered by R4 as needed. R4's record included R4's Individualized Medication Management Plan (IMMP) dated May 15, 2026, which indicated R4 was not able to self-administer medication safely and required supervision and medication management by licensee employees. R4's record lacked an IMMP which reflected a change in resident's medication management services and reflected R4's ability to self-administer R4's sildenafil as needed. On July 30, 2026, at 1:32 p.m., RN-C stated resident medications were administered by licensee's employees unless the resident's EMAR indicated the resident was able to self-administer. RN-C further stated RN-C was unsure why R4's IMMP did not reflect R4's ability to self-administer medication and required an update. The licensee's undated Medication Management Program policy indicated at the time of assessment, the RN determined with the resident and the resident's representative(s) what	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01710	Continued From page 50 medication management services were to be provided. The policy did not address resident self-administration of medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure, prior to delegating the task of medication administration, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and failed to ensure the RN evaluated the ULPs' ability to competently perform the task for two of two employees (ULP-D, ULP-E). This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01750	Continued From page 51 or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: This resulted in an immediate correction order on July 28, 2026. R2's medication administration record (MAR) dated July 1, 2026, through July 31, 2026, indicated ULP-D administered oral medication on July 9-11, 13-15, 21-23, and 27, 2026. In addition, R2's MAR indicated ULP-E administered oral medication to R2 on Jul 16, 20, and 24, 2026. ULP-D ULP-D was hired on May 21, 2026, to provide assisted living services. On July 27, 2026, at 12:27 p.m., the surveyor observed ULP-D obtain R2's medications from the locked medication cabinet. The surveyor observed ULP-D obtain R2's blood glucose reading of 113 milligrams/deciliter (mg/dl), apply a single use needle to R2's Novolog (insulin) pen, dial to five units, and administer in R2's lower left abdomen. ULP-D then documented services as complete. On July 28, 2026, from 7:11 a.m. until 8:45 a.m., the surveyor observed ULP-D administer scheduled medications to R2, R3, R4, and R5. ULP-D's employee record lacked documentation which demonstrated ULP-D had received training and demonstrated competency of all medication	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01750	Continued From page 52 routes of administration with a registered nurse (RN). ULP-E ULP-E was hired on July 14, 2026, to provide assisted living services. ULP-E's employee record lacked documentation which demonstrated ULP-E had received training and demonstrated competency of all medication routes of administration with a RN. On July 27, 2026, at 3:23 p.m., owner/licensed assisted living director (O/LALD)-A stated ULP-E had completed Educare (online education platform) modules and watched an instruction video however, O/LALD-A was unsure if an RN completed competency testing with ULP-E. On July 27, 2026, at 3:37 p.m., ULP-E stated ULP-E had not completed any competency testing which included medication routes, with an RN and ULP-E began working independently for the provider on Saturday, July 25, 2026. On July 28, 2026, at 9:03 a.m., ULP-D stated ULP-D was unable to recall completing competency testing with an RN and that ULP-D learned hands-on skills during ULP-D's on-the-job training. On July 28, 2026, at 1:17 p.m., O/LALD-A stated competencies not located in the above employee files were not completed. O/LALD-A further stated the licensee's RN's have been unable to keep up with training of new employees due to high turnover recently. The licensee's Staff Competency policy dated January 1, 2023, indicated unlicensed personnel	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01750	Continued From page 53 were not allowed to work for [licensee] until successful completion of competency evaluation for administration of medication and treatments as required. The licensee's Medication Administration policy dated August 1, 2021, indicated the RN may delegate medication administration to an ULP according to the following protocol: - all ULP have passed a competency evaluation with respect to all medication routes to be administered; - the RN had prepared written instructions for the ULP in the proper methods to administer medication with respect to each resident; and - the RN has communicated with or provided orientation to the ULP related to the individual need of the resident. The licensee's Personnel Records policy dated January 1, 2023, indicated personnel records would include competency evaluations. Manufacturer's instructions for Novolog (fast acting insulin) revised February 2023, indicated side effects of the medication included dizziness, confusion, blurred vision, slurred speech, shakiness, increased heart rate, anxiety, and death. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750			
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01950	Continued From page 54 other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks of treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform blood glucose testing and the ULP demonstrated competency back to the registered nurse (RN) for two of two employees (ULP-D, ULP-E). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
01950	Continued From page 55 This resulted in an immediate correction order on July 29, 2026. During the entrance conference on July 27, 2026, at 11:17 a.m., registered nurse (RN)-C stated upon hire ULPs completed online training, ULPs shadowed other ULPs, and ULPs completed skills competency test-outs with an RN prior to working independently. ULP-D ULP-D was hired on May 21, 2026, to provide assisted living services. On July 27, 2026, at 12:27 p.m., the surveyor observed ULP-D complete glucose testing via manual finger poke for R2. ULP-E ULP-E was hired on July 14, 2026, to provide assisted living services. ULP-D and ULP-E employee records lacked sufficient evidence to demonstrate ULP-D and ULP-E were trained for blood glucose testing by the RN and demonstrated blood glucose testing competency back to the RN. On July 27, 2026, at 3:23 p.m., owner/licensed assisted living director (O/LALD)-A stated ULP-E had completed Educare (online education platform) modules and watched an instruction video however, O/LALD-A was unsure if an RN completed competency testing with ULP-E. On July 27, 2026, at 3:37 p.m., ULP-E stated ULP-E had not completed any competency testing which included blood glucose testing, with an RN and ULP-E began working independently	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(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
01950	Continued From page 56 for the provider on Saturday, July 25, 2026. On July 28, 2026, at 9:03 a.m., ULP-D stated ULP-D was unable to recall completing competency testing with an RN and that ULP-D learned hands-on skills during ULP-D's on-the-job training. On July 28, 2026, at 1:17 p.m., O/LALD-A stated competencies not located in the above employee files were not completed. O/LALD-A further stated the licensee's RN's have been unable to keep up with training of new employees due to high turnover recently. The licensee's Staff Competency policy dated January 1, 2023, indicated unlicensed personnel were not allowed to work for [licensee] until successful completion of competency evaluation for administration of medication and treatments as required. The licensee's Personnel Records policy dated January 1, 2023, indicated personnel records would include competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01950			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
02290	Continued From page 57 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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: During the entrance conference on July 27, 2026, at 10:49 a.m., owner/licensed assisted living director (O/LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2 was admitted to the licensee and began receiving assisted living services on December 15, 2025. R2's [licensee] Summary of Important Terms (contract) was signed on December 15, 2025. On July 27, 2026, at 12:31 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled medication. R3 R3 was admitted to the licensee and began receiving assisted living services on November 13, 2023.	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379		
(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
02290	Continued From page 58 R3's [licensee] Summary of Important Terms (contract) was signed on November 13, 2023. On July 27, 2026, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's scheduled medication. R4 R4 was admitted to the licensee and began receiving assisted living services on July 24, 2025. R4's [licensee] Summary of Important Terms (contract) was signed on July 24, 2025. On July 28, 2026, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R4's scheduled medication. On page eight of R2, R3, and R4's contracts, respectively, under section 14. Occupancy and Use of the Room, letter C: Visitors, the contract read, "The Community does have restricted visiting hours from 7am to 12 midnight because of mental health population we serve and the need to keep all residents safe. You are responsible for the behavior of your guests while at the Community. All visitors are expected to follow the Community's visitor policies." On July 27, 2026, at 1:18 p.m., O/LALD-A stated the licensee limited visiting hours to promote adequate rest for residents at night and O/LALD was unaware the licensee was not allowed to restrict visiting hours. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER GENESIS ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379			
(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
02290	Continued From page 59 (21) days	02290			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

GENESIS ASSISTED LIVING LLC
1019 South Madison Street
Shakopee, MN 55379
Scott County
Parcel:

Phone:

License Info

License: HFID 39771

Risk:
License:
Expires on:
CFPM: JOAN CHEPCHUMBA MISOI
CFPM #: 9742; Exp: 2-2-2028

Inspection Info

Report Number: F1062261156
Inspection Type: Full - Single
Date: 7/27/2026 Time: 12:00 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection completed on behalf of Allison Skillingstad (HRD).

FACILITY USES TWO BASIN SINK WITH ONE BASIN DEDICATED TO HANDWASHING. LAMINATE COUNTERS AND WALL IN KITCHEN. TILE FLOOR.

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

I acknowledge receipt of the Metro District Office inspection report number F1062261156 from 7/27/2026

JOAN MISOI
OPERATOR

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
GENESIS ASSISTED LIVING LLC	Report Number: F1062261156
Shakopee	Inspection Type: Full
County/Group: Scott County	Date: 7/27/2026
	Time: 12:00 pm

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

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

GENESIS ASSISTED LIVING LLC
Shakopee
County/Group: Scott County

Inspection Info

Report Number: F1062261156
Inspection Type: Full
Date: 7/27/2026
Time: 12:00 pm

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

Location: Kitchen **Equal To** 180 Degrees F.

Comment: MEASURE TAKEN FROM FACILITY'S THERMOLABEL RECORDS FOR THE WEEK OF JULY 26TH.

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39771016-0	Date: 7/29/2026
Facility Name: GENESIS ASSISTED LIVING LLC	
Facility Address: 1019 SOUTH MADISON STREET SHAKOPEE, MN 55379	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

-
1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
 2. Window wells with a vertical depth of more than 44 inches shall be equipped with an approved permanently affixed ladder or steps. Ladders or rungs shall have an inside width of at least 12 inches, shall project at least 3 inches from the wall and shall be spaced not more than 18 inches on center vertically for the full height of the window well. The ladder or steps shall not encroach into the required dimensions of the window well by more than 6 inches. The ladder or steps shall not be obstructed by the emergency escape and rescue opening. Ladders or steps required by this section are exempt from the stairway requirements of Sections 1011 and 1104.10 through 1104.13. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.5.2]

Comments: The egress window well for resident room 5 was more than 44 inches deep. A ladder is required in the egress wells with a vertical depth of more than 44 inches.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: Review of the licensee fire drill log indicated no overnight fire drill was conducted.