Electronically Delivered

October 16, 2026

Licensee
The Beatitudes Homes LLC
3812 Commodore Drive
Brooklyn Center, MN 55429

RE: Project Number(s) SL36744016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 27, 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:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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/Bm5uQEpHVa**. 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,



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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36744	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BEATITUDES HOMES LLC	3812 COMMODORE DRIVE BROOKLYN CENTER, MN 55429

(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: SL36744016-0 On August 24, 2026, through August 27, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents; all of whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 24, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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

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0 650	Continued From page 4 ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on August 24, 2026, at 10:24 a.m., owner/registered nurse (O/RN)-A and clinical nurse supervisor (CNS)-B stated CNS-B was responsible for the training and competencies and licensed assisted living director (LALD)-C completed the performance reviews. ULP-D was hired on October 18, 2024, to provide assisted living services. ULP-E was hired on June 23, 2024, to provide assisted living services. ULP-F was hired on January 3, 2020, and began providing assisted living services on August 1, 2021. DOCUMENTATION OF COMPENTENCIES ULP-D On August 24, 2026, at 10:10 a.m., the surveyor arrived at the facility to initiate the survey and observed ULP-D answer the door and ULP-D stated she was working on the floor. About an hour later, the surveyor observed ULP-D cooking lunch and hand-washing dishes in the kitchen.	0 650		

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0 650	Continued From page 5 ULP-D's training record lacked documentation of ULP-D demonstrating competency performing delegated tasks for the following: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -assisting with toileting; -standby assistance techniques and how to perform them; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medication via inhaler; and -oxygen therapy. On August 25, 2026, at 12:40 p.m., ULP-D stated they were trained by CNS-B on oxygen therapy, administering inhaled medications, bathing, and transfers. ULP-E On August 25, 2026, between 8:10 a.m. and 9:05 a.m., the surveyor observed ULP-E administer medication to R2, R3, and R4. ULP-E's training record lacked documentation of ULP-E demonstrating competency performing delegated tasks for the following: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -standby assistance techniques and how to perform them; -range of motion and positioning; - administering medication via inhaler; and -oxygen therapy. On August 25, 2026, at 12:00 p.m., CNS-B stated	0 650		

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0 650	Continued From page 6 the licensee did not have a form to document oxygen competencies for staff but knew she did one-on-one training and competencies for reach staff person. CNS-B stated they did not have documentation of vital sign and inhaler competencies also. A half hour later, CNS-B stated they found an oxygen competency form they could use going forward and that it was an oversight on their end. During phone interview on August 27, 2026, at 9:56 a.m., ULP-D stated they were trained by the nurse how to administer inhalers. PERFORMANCE REVIEWS ULP-D's record lacked a performance review for year 2025. ULP-E's record included a 30-day performance review dated September 6, 2024. ULP-E lacked performance reviews for years 2025 and 2026. ULP-F's record included completed performance reviews on October 28, 2021, and February 20, 2024. ULP-F lacked performance reviews for years 2022, 2023, 2025, and 2026. During interview on August 25, 2026, at 1:13 p.m., LALD-C stated he had completed performance reviews up to 2024, then passed the task to CNS-B because it had a clinical portion to the form. LALD-C was not sure why CNS-B thought it was still his responsibility to complete performance reviews because he stated he had talked to CNS-B about this in the past. The licensee's 5.02 Competency Training Evaluations policy effective October 11, 2021, indicated if the registered nurse (RN) delegated tasks, prior to the delegation of services they	0 650		

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0 650	Continued From page 7 must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy also indicated a copy of all education, training, and competency testing shall be kept in each employee's personnel file. The licensee's 4.35 Employee Evaluation policy effective October 11, 2021, indicated all staff of the licensee would be given an employee evaluation at least annually. The policy indicated person responsible for completing performance reviews were the "supervisors." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	0 660		

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0 660	Continued From page 8 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an accurately completed facility TB risk assessment using current data. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated April 25, 2026, indicated the facility was at a low risk for TB transmission. The licensee lacked an accurate TB assessment due to the following: -incidence of TB- national rate indicated 2.5 per 100,000 for year 2026 (should have been 3.0 per 100,000 for year 2025); -incidence of TB-Minnesota (MN) rate indicated 2.3 per 100,000 for year 2026 (should have been 3.4 per 100,000 for year 2025); -county data indicated 3.4 per 100,000 for year 2026 (Hennepin County was 5.8 for year 2025); -categories of health care personnel included in licensee's baseline TB screening was left blank; -location of TB screening records stored was left	0 660		

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0 660	Continued From page 9 blank; -names and titles of health care setting's infection control committee members were left blank; -assessment did not indicate whether the health care setting had a current infection control plan to include TB specific procedures; -assessment did not indicate whether TB training was provided to all health care personnel at the time of hire, and whether TB training was performed annually; and -date of last TB risk assessment was conducted April 25, 2026 (cannot be same date of current assessment). During interview on August 24, 2026, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated she completed that assessment and obtained the national and MN case rates off the Minnesota Department of Health (MDH) website. CNS-B was unaware the 2025 case rates were readily available on the assessment and acknowledged she included incorrect TB case rates, wrote the wrong year, and did not fully complete the assessment. The licensee's 8.16 Tuberculosis Screening policy dated October 11, 2021, indicated the licensee would establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). The facility would maintain a current community TB risk assessment and the assessment would be updated annually, using the data and form provided by MDH. The MDH TB FAQ's last updated June 5, 2026,	0 660		

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0 660	Continued From page 10 indicated each provider licensed by MDH was required to complete a TB risk assessment annually. Completion of this assessment would assist providers in the development of an infection control committee and in determining the frequency of screening. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	Continued From page 11 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 24, 2026, at 12:46 p.m., the surveyor retrieved the red EPP binder from the main area of the main level and asked licensed assisted living director (LALD)-C if he had any part of maintaining the EPP and he stated he did and that some content may be within their electronic record system (Residex). The licensee's EPP included multiple dates (listed below), which lacked evidence of the following required and/or updated content: -missing annual review (lacked documentation stating plan was reviewed, by whom, and what was updated-if applicable); -missing resident quarterly review; -process for emergency preparedness (EP) collaboration; -development of all policies/procedures (P/P)	0 680		

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	36744	A. BUILDING: _____ B. WING _____	08/27/2026

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0 680	Continued From page 12 based on the hazard vulnerability assessment; -arrangement of other facilities; -roles under a waiver declared by secretary; and - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for EP cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - emergency staff strategies; - a communication plan (dated June 28, 2023), that included: - an updated staff list/contact information, and the four (4) residents listed were no longer at the facility; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies (did not have procedures regarding when alternate communication methods are used, and who uses them); and - EP testing/annual testing requirements. On August 24, 2026, at 1:05 p.m., the surveyor asked owner/registered nurse (O/RN)-A if they reviewed and updated the EPP, she stated they did that during meetings, trainings, and drills and provided documentation of the meetings and trainings. At 1:41 p.m., O/RN-A stated residents would relocate to one of their sister facilities. While reviewing the communication plan, O/RN-A	0 680		

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0 680	Continued From page 13 stated part of the communication plan was blank but stated she recalled answering all the missing questions but did not know why it was not included. O/RN-A stated the employee and resident contact list was not current and needed to be updated. O/RN-A stated LALD-C might have updated information within Residex. She also stated they did test their plan using scenarios but LALD-C would have that documentation. Later during the survey, LALD-C stated they did not have updated EPP content to provide. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated October 11, 2021, indicated the licensee would include all elements of appendix Z. The licensee would conduct, at minimum, two emergency preparedness drills every 12 months-these drills did not include the required fire/evacuation drills. One annual exercise would be a full-scale community wide exercise, and second exercise would either be a second full-scale community wide exercise or a table-top exercise. 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		

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0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 15 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 780		

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0 780	Continued From page 16 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 790		

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0 790	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 800		

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0 800	Continued From page 18 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

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0 810	Continued From page 19 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 810		

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0 810	Continued From page 20 affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R2, R3, R4). This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not	0 910		

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0 910	Continued From page 21 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 entrance conference on August 24, 2026, at 10:24 a.m., owner/registered nurse (O/RN)-A and clinical nurse supervisor (CNS)-B stated they had three current residents. On August 25, 2026, between 8:10 a.m., through 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-E administer morning medications to R2, R3, and R4. R2 R2 was admitted for assisted living services on February 21, 2025. R2's Resident Agreement Assisted Living contract signed January 16, 2026, lacked the licensee's health facility identification number (HFID) 36744. The contract also indicated the facility address was 1609 84th Avenue North, Brooklyn Park, and the assisted living licensee's address was 3812 Commodore Drive, Brooklyn Center. The addresses were switched. The agent's last name was her maiden name. R3 R3 was admitted for assisted living services on July 28, 2026. R3's Resident Agreement Assisted Living contract signed July 28, 2026, lacked the licensee's HFID number. The facility address and assisted living licensee address were both listed as 1609 84th	0 910		

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0 910	Continued From page 22 Avenue North, Brooklyn Park. The facility address should have been 3812 Commodore Drive, Brooklyn Center. The contact information for person authorized to accept service of notices and orders was left blank. R4 R4 was admitted for assisted living services on September 15, 2024. R4's Resident Agreement Assisted Living contract signed January 16, 2026, indicated the facility address was 1609 84th Avenue North, Brooklyn Park, and the assisted living licensee's address was 3812 Commodore Drive, Brooklyn Center. The addresses were switched. During interview on August 24, 2026, at 2:00 p.m., O/RN-A stated residents signed a new contract annually and she had a name change about five (5) years ago but forgot to update the contract. At 2:25 p.m., O/RN-A stated she was told by the previous surveyor (survey completed year 2024), that the license number needed to be included in the contract, but the current surveyor explained to O/RN-A the HFID number needed to be included. O/RN-A stated the address and phone number was incorrect on all three contracts, acknowledged her contact information was missing from R3's contract, so she would update all contracts to include current and required content. The licensee's 1.05 Signing an Assisted Living Contract policy dated October 11, 2021, indicated when a prospective resident decided to move into the facility, a signed assisted living contract would be signed and received by the facility. No further information was provided.	0 910		

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0 910	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section	0 940		

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0 940	Continued From page 24 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R2, R3, R4). This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on August 24, 2026, at 10:24 a.m., owner/registered nurse (O/RN)-A and clinical nurse supervisor (CNS)-B stated they had three current residents. On August 25, 2026, between 8:10 a.m., through 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-E administer morning medications to R2, R3, and R4. R2, R3, and R4 were admitted for assisted living services on February 21, 2025, July 28, 2026, and September 15, 2024, respectively. R2, R3, and R4's Resident Agreement Assisted Living contracts signed January 16, 2026, July 28, 2026, and January 16, 2026, respectively, were utilized by the licensee as a contract and	0 940		

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0 940	Continued From page 25 lacked the following required information: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; -whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. During interview on August 24, 2026, at 2:30 p.m., O/RN-A stated residents signed a new contract annually. O/RN-A was not aware the contract was missing the missing required content and took notes stating she would get the contract updated to include all required content.	0 940		

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	36744	A. BUILDING: _____ B. WING _____	08/27/2026

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0 940	Continued From page 26 The licensee's 1.05 Signing an Assisted Living Contract policy dated October 11, 2021, indicated when a prospective resident decided to move into the facility, a signed assisted living contract would be signed and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 27 disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F). This practice resulted in a level two violation (a	01500		

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01500	Continued From page 28 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on August 24, 2026, at 10:24 a.m., owner/registered nurse (O/RN)-A stated they were responsible for assigning Educare courses (online training platform) and annual training were completed around late summer, otherwise, some may have it at various times of the year. ULP-D ULP-D was hired on October 18, 2024, to provide assisted living services. On August 24, 2026, at 10:10 a.m., the surveyor arrived at the facility to initiate the survey and observed ULP-D answer the door and ULP-D stated she was working on the floor. About an hour later the surveyor observed ULP-D cooking lunch and hand-washing dishes in the kitchen. ULP-D's record lacked the following annual training topics: - Assisted Living Bill of Rights (completed on November 16, 2024 (orientation), and January 23, 2026. None for year 2025); - infection control techniques (completed November 25, 2024 (orientation), and January 28, 2026). None for year 2025); and - principles of person-centered planning/service delivery (completed June 1, 2024. None for year	01500		

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01500	Continued From page 29 2025 and 2026). ULP-E ULP-E was hired on June 23, 2024, to provide assisted living services. On August 25, 2026, between 8:10 a.m. and 9:05 a.m., the surveyor observed ULP-E administer medication to R2, R3, and R4. ULP-E's record lacked annual training on the following topics: - Assisted Living Bill of Rights (completed on May 25, 2024, and January 23, 2026. None for 2025); - infection control techniques (completed June 1, 2024, November 13, 2024, and January 24, 2026. None for 2025); and - principles of person-centered planning/service delivery (completed June 1, 2024. None for 2025). ULP-F ULP-F was hired on January 3, 2020, and began providing assisted living services on August 1, 2021. ULP-F's record lacked annual training on the following topics: -Assisted Living Bill of Rights (completed June 21, 2023, November 23, 2024, and March 16, 2026. None for 2025); -infection control techniques (completed January 31, 2023, November 26, 2024, and March 31, 2026. None for 2025); -principles of person-centered planning/service delivery (completed March 21, 2023, November 26, 2024, and March 31, 2026. None for 2025); and -reporting maltreatment of vulnerable adults or minors (completed on July 2, 2023, and	01500		

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01500	Continued From page 30 November 27, 2024. None for 2025). During interview on August 25, 2026, at 12:00 p.m., O/RN-A stated trainings for year 2025 did not appear on ULP transcripts because when the same course was "reassigned," Educare would automatically reset the course. The surveyor asked if that was the reason, then why would the exact courses show up on the transcript for year 2023 and 2024? O/RN-A did not provide further explanation. The licensee's 5.06 Annual Required Staff Training policy dated October 11, 2021, indicated the following training elements must be included every 12 months to all staff who performed direct care services: -training on reporting of maltreatment of vulnerable adults; -review of the assisted living bill of rights; -review of infection control techniques; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures; and -principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530		

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01530	Continued From page 31 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the 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;	01530		

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01530	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that three of three employees (ULP-D, ULP-E, ULP-F) had completed at least two (2) hours of training on topics related to dementia and two of three employees (ULP-D, ULP-E) had completed at least one (1) hour of training topics related to mental illness and de-escalation for each twelve (12) months of employment thereafter. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on August 24, 2026, at 10:24 a.m., owner/registered nurse (O/RN)-A stated they were responsible for assigning Educare courses (online training platform) and annual training were completed around late summer, otherwise, some may have it at various times of the year. ULP-D ULP-D was hired on October 18, 2024, to provide assisted living services. On August 24, 2026, at 10:10 a.m., the surveyor arrived at the facility to initiate the survey and	01530		

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01530	Continued From page 33 observed ULP-D answer the door and ULP-D stated she was working on the floor. About an hour the surveyor observed ULP-D cooking lunch and hand-washing dishes in the kitchen. ULP-D's record lacked annual training on the following: -1.5 hours of dementia training for year 2025 (only completed 0.5 hours on May 8, 2025); and -one (1) hour of mental illness and de-escalation training for year 2026 (last completed mental illness training on May 10, 2025). ULP-E ULP-E was hired on June 23, 2024, to provide assisted living services. On August 25, 2026, between 8:10 a.m. and 9:05 a.m., the surveyor observed ULP-E administer medication to R2, R3, and R4. ULP-E's record lacked annual training on the following topics: -two (2) hours of dementia training for year 2025; and -0.25 hours of mental illness and de-escalation training completed for year 2026 (last completed mental illness training on May 10, 2025). ULP-F ULP-F was hired on January 3, 2020, and began providing assisted living services on August 1, 2021. ULP-F's record lacked annual training on the following topics: -two (2) hours of dementia training for year 2025. During interview on August 25, 2026, at 12:00 p.m., O/RN-A stated trainings for year 2025 did	01530		

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01530	Continued From page 34 not appear on ULP transcripts because when the same course was "reassigned," Educare would automatically reset the course. The surveyor asked if that was the reason, then why would the exact courses show up on the transcript for year 2023 and 2024? O/RN-A did not provide further explanation. The licensee's 5.03 Dementia Training policy effective October 11, 2021, indicated all direct care staff and supervisors would receive two (2) hours of training on topics related to dementia care for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on 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	01610		

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01610	Continued From page 35 planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment on, or before, the date of admission for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated they would complete a pre-screening, then on the day of admission, the registered nurse (RN) would complete the admission assessment and complete the service plan. Next assessment was completed within 14 days, and every 90 days. On August 24, 2026, at 12:37 p.m., the surveyor observed R2 sitting in a manual wheelchair watching television in their room. During conversation with R2, the surveyor observed an oxygen concentrator (filters ambient air to deliver 90-95% pure oxygen) and a high/low bed with bed rails. R2 was admitted to licensee on February 21,	01610		

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01610	Continued From page 36 2025, and had diagnoses including pre-diabetes, chronic pain, elevated blood pressure, and major depressive disorder. R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received services such as with bathing, behavior management, dressing, housekeeping, medication administration, and oxygen delivery. On August 24, 2026, at 3:02 p.m., owner/registered nurse (O/RN)-A stated R2 moved from their sister facility (owned by the same owner) on February 21, 2025, because R2 required a higher level of care and treated this transfer as a new admission. R2's Assessment History by Client as of August 24, 2026, indicated CNS-B completed a clinical update (assessment) on June 10, 2025, September 27, 2025, and June 15, 2026. R2's record lacked an admission assessment. On August 25, 2026, at 12:15 p.m., when the surveyor requested R2's admission and 14-day assessment, CNS-B stated they were not completed. CNS-B explained they were informed after the fact by another surveyor at another facility that whenever a resident transferred from a sister facility, they needed to complete a full admission assessment. The licensee's 6.01 Assessments, Reviews and Monitoring policy effective October 11, 2021, indicated an RN would conduct a nursing assessment 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	01610		

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01610	Continued From page 37 facility or the date on which a prospective resident moves in, whichever is earlier. The policy did not provide instruction for resident transfers between facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring	01620		

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01620	Continued From page 38 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) completed a reassessment 14 days after admission for one of two residents (R2), and a reassessment not to exceed 90 days for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01620		

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	36744	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BEATITUDES HOMES LLC	3812 COMMODORE DRIVE BROOKLYN CENTER, MN 55429

(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 39 situation has occurred only occasionally). The findings include: During entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated they would complete a pre-screening, then on the day of admission, the registered nurse (RN) would complete the admission assessment and complete the service plan. Next assessment was completed within 14 days, and every 90 days. R2 was admitted to licensee on February 21, 2025, and had diagnoses including pre-diabetes, chronic pain, elevated blood pressure, and major depressive disorder. R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received services such as with bathing, behavior management, dressing, housekeeping, medication administration, and oxygen delivery. On August 24, 2026, at 12:37 p.m., the surveyor observed R2 sitting in a manual wheelchair watching television in their room. During conversation with R2, the surveyor observed an oxygen concentrator (filters ambient air to deliver 90-95% pure oxygen) and a high/low bed with bed rails. On August 24, 2026, at 3:02 p.m., owner/registered nurse (O/RN)-A stated R2 moved from their sister facility (owned by the same owner) on February 21, 2025, because R2 required a higher level of care and treated this transfer as a new admission. R2's assessment record indicated the following:	01620		

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01620	Continued From page 40 -Lacked a 14-day assessment (should have been completed no later than March 7, 2025); -Lacked a 90-day assessment (should have been no later than June 5, 2025); -An assessment was completed on June 10, 2025, due to hospitalization; -An assessment was completed on September 27, 2025, due to hospitalization (completed at 104 days); and -An assessment was completed on June 15, 2026- a 90-day assessment (completed at 261 days). The licensee failed to ensure the RN completed a reassessment at 14 days following R2's admission date and further failed to complete a reassessment not to exceed 90 days. On August 25, 2026, at 12:15 p.m., when the surveyor requested R2's admission and 14-day assessment, CNS-B stated they were not completed. Regarding 90-day assessments, CNS-B stated they completed progress notes but did not document the assessment within Residex (electronic health record) and that they only use Residex for documenting assessments. CNS-B stated O/RN-A did not complete resident assessments unless CNS-B was not available. The licensee's 6.01 Assessments, Reviews and Monitoring policy effective October 11, 2021, indicated an RN would conduct a nursing reassessment and monitoring no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

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01620	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan and any revisions were authenticated by the resident or resident's representative and facility representative documenting agreement on the services to be provided for two of three residents	01640		

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01640	Continued From page 42 (R2, 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 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 entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the registered nurse (RN) and the resident go through the service plan then sign it. If the service plan was revised, it would be signed. On August 25, 2026, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2, R3, and R4. R2 R2 was admitted to licensee on February 21, 2025, and had diagnoses including pre-diabetes, chronic pain, elevated blood pressure, and major depressive disorder. R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received services such as with bathing, behavior management, dressing, housekeeping, medication administration, and oxygen delivery. R2's service plan lacked authentication by both the resident and the facility representative. On August 24, 2026, at 2:00 p.m., owner/RN	01640		

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01640	Continued From page 43 (O/RN)-A stated R2 always refused to sign any document but they went through the service plan with them. The surveyor asked if there was documentation of R2's refusal to sign the service plan, O/RN-A stated no, then wrote "client refused to sign" on the service plan in front of the surveyor but did not sign for the facility. R4 R4 was admitted to licensee on September 15, 2024, and had diagnoses including traumatic brain injury (TBI), left sided weakness, depression, and elevated blood pressure. On August 26, 2026, at 12:38 p.m., the surveyor sent an email requesting R4's current service plan. On August 26, 2026, at 8:47 p.m., via email, CNS-B sent the surveyor R4's assisted living contract. On August 27, 2026, at 7:50 a.m., via email, the surveyor replied to CNS-B by providing a screenshot of what the surveyor was looking for (service plan from R4's electronic health record-Residex). During exit conference on August 27, 2026, at 11:50 a.m., CNS-B stated they were aware the licensee needed to sign the service plan along with the resident. The surveyor again requested R4's service plan. The surveyor never received R4's service plan to review. The licensee's undated 6.08 Service Plan policy indicated service plans and any revisions would include a signature or other authentication by the	01640		

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01640	Continued From page 44 licensee and by the resident, or resident's representative, documenting agreement on services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of 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	01760		

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01760	Continued From page 45 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 August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R3 was admitted to licensee on July 28, 2026, and had diagnoses including phantom limb syndrome with pain, left above the knee amputation, type II diabetes, and anxiety disorder. R3's Service Plan (Waiver) - Addendum to Contract effective July 28, 2026, indicated R3 received assistance with services such as medication administration, bathing, behavior management, nail care, safety checks, and transfer assistance. R3's admission order signed July 15, 2026, ordered gabapentin 600 mg (milligram) tablet orally twice daily for nerve pain. R3's follow-up provider orders signed August 7, 2026, ordered gabapentin 600 mg tablet, 1 tablet twice daily (no change from admission order). R3's medication administration record (MAR) dated August 2026, indicated by staff initials that R3 took the following: -August 1-17, 2026-gabapentin 600 mg capsule, took 2 capsules (1,200 mg-double the ordered dose) twice daily (R3 refused on August 5-6, 2026, at 8:00 a.m.); and -August 18-24, 2026, gabapentin 300 mg	01760		

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01760	Continued From page 46 capsule, took 2 capsules (600 mg) by mouth three times a day (changed from twice daily to three times daily). During observation on August 25, 2026, at 8:37 a.m., unlicensed personnel (ULP)-E set up famotidine 20 mg tablet (reduces stomach acid) then the MAR indicated gabapentin 300 mg, two capsules by mouth three times daily, so ULP-E grabbed R3's prescription bottle labeled gabapentin 600 mg and took out two tablets (not capsules) and placed them into the medication cup with the famotidine. When ULP-E stood up and grabbed the bin to put away, the surveyor asked ULP-E to check the gabapentin bottle again. ULP-E stated the MAR indicated two capsules [tablets], so the surveyor asked ULP-E what the dose on the gabapentin bottle indicated, ULP-E then realized the dose was different. ULP-E asked the surveyor what they should do, the surveyor advised ULP-E to contact the on-call registered nurse (RN) for further instruction. ULP-E spoke with the on-call nurse, got off the phone then came back to the MAR and said the nurse instructed them to follow what the MAR indicated. The surveyor again explained to ULP-E the dose would be incorrect (double) if they set up two tablets. ULP-E stated they needed to give two tablets per nurse, then licensed assisted living director (LALD)-C walked into the kitchen so the surveyor had LALD-C look at the issue which they confirmed the dose was incorrect. ULP-E set up one tablet and administered the medications to R3. During interview on August 25, 2026, at 9:40 a.m., owner/registered nurse (O/RN)-A stated ULP-E had contacted them regarding R3's gabapentin. During their phone conversation, O/RN-A explained that ULP-E stated the MAR	01760		

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01760	Continued From page 47 instructed to give two capsules, but the prescription bottle said one tablet. O/RN-A instructed ULP-E to follow the MAR, not the bottle but explained ULP-E did not indicate the strengths were different. O/RN-A observed the MAR and the prescription bottle and said if staff had given two tablets, the dose would have been 1,200 mg, not 600 mg. O/RN-A also stated R3 came with their medications, some were in bubble packs and some were in bottles and their pharmacy had not yet delivered medications as they were using up the current supply. O/RN-A stated they would need to update the MAR. R3's gabapentin 600 mg bottle was dispensed by another pharmacy on July 15, 2026, with quantity of 60 tablets (one month supply per admission order), and during observation there were 3 tablets left (should have ran out around August 15, 2026). R3's medication bin did not contain additional gabapentin except for another resident's gabapentin 300 mg (R1) which may have been used. During phone interview on August 27, 2026, at 9:56 a.m., ULP-E stated they always took one tablet from the bottle. The surveyor asked why they took two tablets from the bottle, ULP-E explained the directions on the MAR changed as it used to say 1 tablet and they always checked for accuracy. R3's August MAR never indicated to give one tablet of gabapentin, it only indicated two tablets. R3's prescription bottle did indicate to give one tablet at a higher strength. Prior to the observation, ULP-E documented 10 times that two tablets were given between August 1-20, 2026. It was unknown what dose of gabapentin R3 was taking due to discrepancies of the order,	01760		

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01760	Continued From page 48 MAR, and medication supply. The licensee's 5.02 Competency Training Evaluations policy effective October 11, 2021, indicated the RN would determine what nursing services may be delegated to properly trained and competency tested ULP. Training and competency evaluations for all ULPs would include administering medications such as administering medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	01820		

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01820	Continued From page 49 situation has occurred only occasionally). The findings include: During the entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. During observation on August 25, 2026, at 8:10 a.m., unlicensed personnel (ULP)-E set up and administered the following morning medications for R2: -acetaminophen 500 mg (milligrams) tablet, one tablet by mouth every six (6) hours for pain; -duloxetine 30 mg extended release (ER) capsule, one capsule by mouth once daily for depression; -furosemide 40 mg tablet, one tablet by mouth once daily for edema; -methocarbamol 500 mg tablet, one tablet by mouth every eight (8) hours for musculoskeletal pain; -vitamin D3 25 mcg (micrograms) capsule, one capsule by mouth once daily as supplement; -Dulera 200-5 mcg inhaler two puffs twice daily to control and prevent asthma; and -Spiriva Respimat 2.5 mcg inhaler two puffs once daily to relax muscles in airway to increase airflow. R2 was admitted to licensee on February 21, 2025, and had diagnoses including pre-diabetes, chronic pain, elevated blood pressure, and major depressive disorder. R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received assistance with medication administration.	01820		

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01820	Continued From page 50 R2's medication administration record (MAR) dated August 2026, indicated R2 was taking acetaminophen 500 mg tablet, one tablet every 6 hours for pain; furosemide 40 mg tablet, one tablet once daily for edema; olanzapine 15 mg tablet, one tablet daily at bedtime depression; Aquaphor ointment, apply topically to upper thigh as needed (PRN) for redness; and benzonatate 100 mg capsule, two capsules three time daily PRN for cough. R2's record lacked prescriber orders for scheduled acetaminophen, furosemide, olanzapine (record included olanzapine 10 mg order dated February 10, 2026, but no orders were available for 15 mg), Aquaphor, and benzonatate. On August 24, 2026, at 3:22 p.m., CNS-B stated she spoke with R2's provider during a virtual visit and the provider discontinued the PRN acetaminophen and scheduled it. The provider stated they would fax it to the licensee which CNS-B was unable to locate. On August 27, 2026, at 11:07 a.m., via email, CNS-B indicated medication orders were sent directly to the pharmacy then she received the "Pharmacy Connect or Rtask (electronic health record). Sometimes the pharmacy techs will notify me of order changes or new orders; sometimes they don't, depending on the staff on duty. Hence, for me to find changes, it is when I check Rtask or orders and complete the Pharmacy Connect. Providers never call me; they always speak with the pharmacist. With that said, I can call [pharmacy name] to fax me the orders; I am sure they will have the orders."	01820		

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01820	Continued From page 51 The licensee's 7.20 Medication & Treatment Orders policy effective October 11, 2021, indicated the licensee would ensure a current, written prescriber's order would be obtained for medication administration provided to a resident. The policy also indicated upon receiving verbal orders or unsigned electronic orders, the RN would record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The RN would continue to follow-up with the prescriber's office until the signature was received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01830		

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01830	Continued From page 52 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. During observation on August 25, 2026, at 8:10 a.m., unlicensed personnel (ULP)-E set up and administered the following morning medications for R2: -acetaminophen 500 mg (milligrams) tablet, one tablet by mouth every six (6) hours for pain; -duloxetine 30 mg extended release (ER) capsule, one capsule by mouth once daily for depression; -furosemide 40 mg tablet, one tablet by mouth once daily for edema; -methocarbamol 500 mg tablet, one tablet by mouth every eight (8) hours for musculoskeletal pain; -vitamin D3 25 mcg (micrograms) capsule, one capsule by mouth once daily as supplement; -Dulera 200-5 mcg inhaler two puffs twice daily to control and prevent asthma; and -Spiriva Respimat 2.5 mcg inhaler two puffs once daily to relax muscles in airway to increase airflow. R2 was admitted to licensee on February 21, 2025, and had diagnoses including pre-diabetes, chronic pain, elevated blood pressure, and major depressive disorder. R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36744	A. BUILDING: _____ B. WING _____	08/27/2026

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01830	Continued From page 53 received assistance with medication administration. R2's record included the following expired medication orders signed January 7, 2025: -methadone 85 mg/ml (milliliters), once daily for chronic pain; and -vitamin D3 25 mcg, once daily; -diclofenac 1% gel, apply 2-4 grams to knees four times daily as needed for pain (PRN); and -ventolin 90 mcg inhaler, inhale 2 puffs by mouth every 4 hours PRN for wheezing and cough. R2's record included the following expired medication orders signed July 9, 2025: -Dulera 200 mcg/5 mcg inhaler twice daily; -duloxetine 30 mg once daily; -gabapentin 300 mg three times daily; -hydrophor ointment, apply topically to upper thigh PRN for redness; -methocarbamol 500 mg every 8 hours; -nicotine gum 4 mg, chew one piece every hour PRN for nicotine craving; and -Spiriva Respimat 2.5 mcg inhaler once daily. On August 24, 2026, at 3:22 p.m., the surveyor requested current provider orders because the orders received were dated January 7, 2025, then owner/registered nurse (O/RN)-A stated during annual contract signing (beginning of every year), they submitted orders to the clinic to be signed by the provider. The surveyor requested the current orders again so O/RN-A and CNS-B began looking around. CNS-B stated she spoke with R2's provider over the phone where R2 completed a virtual visit and the provider had discontinued the as needed acetaminophen and scheduled it. At that visit, CNS-B stated the provider would fax the order to the licensee but they were unable to locate it.	01830		

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01830	Continued From page 54 On August 24, 2026, at approximately 4:00 p.m., the surveyor observed CNS-B on the phone with R2's clinic attempting to obtain prescriber orders. On August 27, 2026, at 11:07 a.m., via email, CNS-B indicated medication orders were sent directly to the pharmacy then she received the "Pharmacy Connect or Rtask (electronic health record). Sometimes the pharmacy techs will notify me of order changes or new orders; sometimes they don't, depending on the staff on duty. Hence, for me to find changes, it is when I check Rtask or orders and complete the Pharmacy Connect. Providers never call me; they always speak with the pharmacist. With that said, I can call [pharmacy name] to fax me the orders; I am sure they will have the orders." The licensee's 7.20 Medication & Treatment Orders policy effective October 11, 2021, indicated the licensee would ensure a current, written prescriber's order would be obtained for medication administration provided to a resident. The RN would communicate with the prescriber to ensure that the prescriber renewed a medication order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

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01880	Continued From page 55 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services for licensee's residents. The current census was three (3) residents. During observation on August 25, 2026, at 8:10 a.m., the surveyor observed a galley style kitchen with the refrigerator and stove on one side and sink and cabinets on the other side. Unlicensed personnel (ULP)-E washed their hands at the kitchen sink, put on gloves and retrieved keys from a small drawer between the refrigerator and stove. ULP-E then opened a kitchen cabinet that housed medication for four (4) residents (three	01880		

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01880	Continued From page 56 current, and one discharged). R2 was already sitting at the kitchen table eating breakfast. ULP-E set up and administered R2's medications at the kitchen table. ULP-E then set up R4's medication, put the medication bin back into the cabinet, locked it, then put the keys back into the same drawer (R2 was still sitting at the table and able to see everything). After ULP-E administered R4's medications while in their room, ULP-E came back into the kitchen, grabbed the keys from the drawer, performed hand hygiene, put on gloves and set up R3's medication. The surveyor did not observe if ULP-E put the keys back into the drawer because R4 had fallen at the front door so ULP-E, licensed assisted living director (LALD)-C, and owner/registered nurse (O/RN)-A were all with R4. On August 25, 2026, at 12:10 p.m., the surveyor asked O/RN-A and CNS-B how medication keys should be stored, and both said "on their person." The surveyor explained what was observed during medication pass that morning so O/RN-A went upstairs to see if keys were in the drawer. O/RN-A came back downstairs and stated they found keys in the drawer the surveyor described and that they would re-train staff as they had already been trained. During phone interview on August 27, 2026, at 9:16 a.m., ULP-D stated they stored medication keys on them, but because they had left the facility with the keys and had to return them, they put the keys in the drawer toward the end of the shift. When the next shift staff asked for the keys, they would direct them to the drawer. The licensee's 7.11 Medication Storage policy effective October 11, 2021, indicated when medications managed outside of a resident's	01880		

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01880	Continued From page 57 "living space" must be in a securely locked and substantially constructed compartments and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription drug supply for one of one resident (R1) was not saved for use by anyone other than the resident for which the medication was prescribed. The deficient practice had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 August 24, 2026, at 10:24 a.m., clinical nurse supervisor	01900		

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01900	Continued From page 58 (CNS)-B stated the licensee provided medication management services for licensee's residents. On August 24, 2026, around 3:00 p.m., CNS-B provided R1's medication disposition form and explained when R1 moved out, they did not take their medications with but the licensee was recently contacted by R1 or a representative for R1 stating they would pick up R1's medications within a weeks' time. On August 25, 2026, at 8:37 a.m., the surveyor observed unlicensed personnel (ULP)-E grab keys from a drawer within the kitchen, open the kitchen cabinet, and pull out R3's bin of medications then place them on the kitchen table next to the laptop. The surveyor observed R1's (discharged resident) medications on the shelf with other resident's medications. While looking at the medication administration record (MAR), it instructed staff to give gabapentin 300 milligram (mg), two (2) capsules (600 mg) by mouth three times per day (for pain). ULP-E located a prescription bottle of gabapentin 600 mg and pulled out two caplets (1,200 mg) and placed them in the medication cup along with other pills. When ULP-E stood up and grabbed the bin, the surveyor asked ULP-E to check the gabapentin bottle again. ULP-E stated the MAR indicated two capsules, so the surveyor asked ULP-E what the dose on the gabapentin bottle said, ULP-E then realized the dose was different. ULP-E looked at all the bubble packs within the bin and found R1's gabapentin 300 mg capsule bubble pack. R3's bin did not include any additional gabapentin for R3. ULP-E asked the surveyor "what should I do?" The surveyor suggested ULP-E contact the on-call nurse for instruction. ULP-E called the nurse and left a message on the voicemail. The surveyor asked ULP-E if they had used R1's	01900		

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01900	Continued From page 59 gabapentin for R3 in the past, and ULP-E stated, "I do not know why that is in the bin." ULP-E made contact with the nurse and the nurse had instructed ULP-E to follow what the MAR said and got off the phone. ULP-E stated the nurse instructed them to follow what the MAR said which was two caplets. ULP-E stated they needed to give two caplets per nurse, then licensed assisted living director (LALD)-C walked into the kitchen so the surveyor had LALD-C look at the issue which they confirmed the dose was incorrect, and that R1's gabapentin was in R3's medication bin. On August 25, 2026, at 9:40 a.m., when owner/registered nurse (O/RN)-A was made aware that R1's gabapentin was in R3's medication bin, O/RN-A was surprised to hear that was in R3's medication bin and stated they would remove R1's medication from the cabinet and bring them downstairs. R1's medication disposition form signed by CNS-B on June 16, 2026, indicated 19 capsules of gabapentin 300 mg (prescription number 6400272) remained. R1's gabapentin 300 mg capsule bubble pack found in R3's medication bin contained nine (9) capsules (prescription number 6400272). During phone interview on August 27, 2026, at 9:16 a.m., ULP-D stated for R3, they took one caplet of gabapentin from R3's bottle and never took gabapentin from R1's bubble pack. During phone interview on August 27, 2026, at 10:00 a.m., ULP-E stated they always took one caplet from the bottle, then the surveyor asked why they took two from the bottle during	01900		

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01900	Continued From page 60 observation, they said the directions on the EMAR changed as it used to say one, but now said two. For R1's bubble pack, that morning during observation, that was the first time they seen it. During phone interview on August 27, 2026, at 11:08 a.m., the surveyor explained that R1's disposition form indicated 19 capsules remained but R1's gabapentin bubble pack had 9 capsules remaining (difference of 10 capsules), CNS-B stated it could have been an error that they wrote 19 instead of 9 but could not explain why R1's bubble pack was in R3's bin. The licensee's 7.11 Mediation Storage policy effective October 11, 2021, indicated medications managed by the licensee would be stored to prevent diversion of medications by residents or others who may have access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided	01960		

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	36744	A. BUILDING: _____ B. WING _____	08/27/2026

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01960	Continued From page 61 to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to transcribe treatment orders as prescribed for one of one resident (R2) utilizing oxygen therapy. 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 entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated R2 was supposed to be on continuous oxygen but did not wear it all the time. No other treatments were provided. On August 24, 2026, at 12:37 p.m., the surveyor observed R2 sitting in a manual wheelchair watching television in their room. During conversation with R2, the surveyor observed an oxygen concentrator (filters ambient air to deliver 90-95% pure oxygen) not in use but stored within R2's room. R2 was admitted to licensee on February 21, 2025, and had diagnoses including chronic obstructive pulmonary disease (COPD), pre-diabetes, chronic pain, elevated blood pressure, and major depressive disorder.	01960		

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01960	Continued From page 62 R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received services such as with oxygen delivery, bathing, behavior management, dressing, housekeeping, and medication administration. R2's medication administration record (MAR) dated August 2026, indicated the following: -oxygen (daily) 2 L/min (liters per minute), "Patient's sats (saturation) should be less than 85 percent (%) or equal to 88% Oxygen 2 L/min via nasal cannula continuously: Patients [sic] sats should be less that [sic] 85% or Equal [sic] to 88% (levels below 90% are considered low and potentially dangerous). Document if resident is refusing to use her oxygen." Scheduled for AM (morning), PM (evening), and overnight. R2's hospital discharge orders dated June 16, 2025, ordered 2 L/min during activity and patient's sats must be less than or equal to 88%. RA (room air) at rest, 2L with activity and while sleeping. On August 27, 2026, at 8:36 a.m., via email, the surveyor asked for clarification on the oxygen instructions as it indicated R2's saturation level should be less than 85% or equal to 88% (invalid instructions). On August 27, 2026, at 2026, at 11:07 a.m., via email, CNS-B indicated she copied the instructions from the discharge oxygen orders (included order number, provider name) which matched the discharge orders dated June 16, 2025, listed above (instructions on MAR should have been-patients saturation must be less than or equal to 88%, room air at rest and 2L of oxygen with activity and while sleeping). R2's oxygen orders were transcribed incorrectly.	01960		

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01960	Continued From page 63 The licensee's 7.22 Medications & Treatment Record-Documentation & Refusal policy effective October 11, 2021, indicated the licensee would create and maintain a correct and accurate medication and/or treatment record for each resident receiving medication assistance or administration and or treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment orders were renewed at least every 12 months for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01970		

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01970	Continued From page 64 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 entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated R2 was supposed to be on continuous oxygen but did not wear it all the time. No other treatments were provided. On August 24, 2026, at 12:37 p.m., the surveyor observed R2 sitting in a manual wheelchair watching television in their room. During conversation with R2, the surveyor observed an oxygen concentrator (filters ambient air to deliver 90-95% pure oxygen) not in use but stored within R2's room. R2 was admitted to licensee on February 21, 2025, and had diagnoses including chronic obstructive pulmonary disease (COPD), pre-diabetes, chronic pain, elevated blood pressure, and major depressive disorder. R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received services such as with oxygen delivery, bathing, behavior management, dressing, housekeeping, and medication administration. On August 24, 2026, at 3:22 p.m., during R2's record review, the surveyor requested R2's current provider orders because the orders in the record were dated January 7, 2025. CNS-B stated when they submit orders annually to be signed around the time the resident signs their assisted living contract. CNS-B and owner/registered nurse (O/RN)-A both looked for	01970		

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01970	Continued From page 65 R2's current orders. CNS-B then stated she spoke with the provider over the phone for R2's virtual appointment and was told by the provider that they would fax the orders but could not locate them. The surveyor asked where the oxygen order originated from, CNS-B stated R2 was prescribed oxygen while at the hospital. R2's Discharge Oxygen dated June 16, 2025, provided via email on August 27, 2026, at 11:07 a.m., ordered two (2) liters (L) of oxygen during activity or when R2's oxygen saturation is less than or equal to 88% (adequate level is typically 92% or above). Room air at rest. On August 27, 2026, at 12:53 p.m., via email, CNS-B indicated the screenshot of certification periods were their attempt to get orders signed and also called and spoke with the clinic (during the surveyors presence on August 24, 2026) to try and obtain orders which they did not get what they requested: -February 21, 2025, through February 21, 2026 (needed signature); -February 22, 2026, through February 22, 2027 (needed signature); and -February 23, 2027, through February 23, 2028 (needed signature). R2's record lacked current oxygen orders or documentation of the RN attempting to get the oxygen orders renewed. The licensee's 7.20 Medication & Treatment Orders policy effective October 11, 2021, indicated the RN would ensure a current, written prescriber's order would be obtained for any treatment provided to a resident. Additionally, the RN would communicate with the prescriber to assure the prescriber renews a medication or	01970		

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	36744	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BEATITUDES HOMES LLC	3812 COMMODORE DRIVE BROOKLYN CENTER, MN 55429

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01970	Continued From page 66 treatment/therapy order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for two of two residents (R2, R4) with hospital-style bed rails (also known as side rails). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2	02310		

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02310	Continued From page 67 On August 24, 2026, at 12:37 p.m., the surveyor observed R2 sitting in her manual wheelchair watching television within her room. The surveyor introduced themselves and initiated conversation. The surveyor observed a hospital bed with raised upper bilateral (2) bed rails made of metal. The bed rails felt secure (did not pull away from the bed frame or move side to side). R2 stated she used the bed rails to help reposition herself while in bed. R2 was admitted to licensee on February 21, 2025, and had diagnoses including pre-diabetes, chronic pain, elevated blood pressure, and major depressive disorder. R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received services such as with bathing, behavior management, dressing, housekeeping, medication administration, and oxygen delivery. R2's Assessment by Date (nursing assessment) completed remotely by clinical nurse supervisor (CNS)-B on June 15, 2026, indicated R2 had a hospital bed with half-length bed rails for bed mobility and fall prevention during transfers. Bed rails were securely attached, in good working condition, free of defects or wear, and checked regularly for safety. The assessment also included entrapment zone measurements for zones 1 through 7. R4 On August 25, 2026, at 8:10 a.m., unlicensed personnel (ULP)-E set up R4's medications in the kitchen area. ULP-E then brought R4's medications to his room where he was sitting in his manual wheelchair watching television. While ULP-E was administering R4's medications, the	02310		

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02310	Continued From page 68 surveyor observed a hospital bed with raised upper bilateral bed rails made of metal. R4 was admitted to licensee on September 15, 2024, and had diagnoses including traumatic brain injury (TBI), left sided weakness, depression, and elevated blood pressure. On August 26, 2026, at 12:38 p.m., the surveyor sent an email requesting R4's current service plan. The surveyor never received R4's service plan to review. R4's Assessment as of Date completed remotely by CNS-B on June 15, 2026, indicated as of January 25, 2025, R4 had a hospital bed with bilateral bed rails to assist R4 with pivot transfers and prevent R4 from rolling out of bed while sleeping. Bed rails were securely attached to the bed frame and exhibit no visible damage and functioning correctly. The assessment also included entrapment measurements for zones 1-4 as of January 25, 2025. On September 15, 2025, it was documented "no changes." During interview on August 25, 2026, at 12:50 p.m., the surveyor asked CNS-B if they completed bed rail entrapment zone measurements with every assessment, and CNS-B stated they did not because the "measurements do not change." CNS-B explained at each assessment, they checked for stability, made sure the bed rail was working properly, and made sure screws were not missing. CNS-B stated they were not aware they needed to complete entrapment zone measurements for subsequent assessment and thought initial measurements were sufficient. R2 and R4's records lacked updated	02310		

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02310	Continued From page 69 measurements of the zones of entrapment with subsequent assessments after initial entrapment zone measurements were obtained. The licensee's 6.28 Side Rails policy dated October 11, 2021, indicated the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy also indicated the side rail design should be consistent with the FDA's (Food and Drug Administration) 2006 recommended dimensional measurements to reduce entrapment, which meant side rail zones 1, 2, and 3 must not exceed 4.75." The policy did not indicate how often measurements should be completed. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "Per FDA recommendations, the need for bed rails must be assessed on a "frequent, regular basis." At a minimum this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition." "Additionally, the licensee must ensure that the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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02320	Continued From page 70	02320		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process were followed for one of one unlicensed personnel ((ULP)-E) observed administering medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD- difficulty breathing), chronic pain, elevated blood pressure, and major depressive disorder.	02320		

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02320	Continued From page 71 R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received services such as with bathing, behavior management, dressing, housekeeping, medication administration, and oxygen delivery. R2's Provider Orders signed January 7, 2025, ordered the following: -Dulera 200 mcg (microgram)/5 mcg inhaler (control and prevent asthma), inhale two puffs by mouth twice daily (prior to first use, release 4 test sprays in the air to prime inhaler. Shake well for 5 seconds before each use); and -Spiriva Respimat 2.5 mcg inhaler (relaxes muscles in airway to increase airflow), inhale two puffs by mouth once daily. R2's medication administration record (MAR) dated August 2026, indicated R2 took the following: -Dulera 200 mcg/5 mcg inhaler, inhale two puffs by mouth twice daily (prior to first use, release 4 test sprays in the air to prime inhaler. Shake well for 5 seconds before each use) at 8:00 a.m., and 8:00 p.m.; and -Spiriva Respimat 2.5 mcg inhaler inhale two puffs by mouth once daily at 8:00 a.m. During observation on August 25, 2026, at 8:10 a.m., unlicensed personnel (ULP)-E set up R2's oral medications and placed them into a medication cup. ULP-E then handed R2 the Dulera inhaler, which R2 shook, took the first puff, shook again then took a second puff (R2 took short, quick breaths). R2 handed the inhaler back then ULP-E gave R2 the Spiriva inhaler and completed the exact same process as the Dulera. R2 then took the oral medications with a glass of water. The surveyor did not observe instruction	02320		

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02320	Continued From page 72 from ULP-E to have R2 wait in between puffs or in between the inhalers nor did ULP-E instruct R2 to rinse and spit after taking Dulera. ULP-E's training record lacked documentation of demonstrated competency to the registered nurse (RN) to administer inhaled medication. During phone interview on August 27, 2026, at 9:56 a.m., ULP-E stated they were trained to have resident shake the inhaler, take first puff, then wait 30 seconds, shake again before second puff. ULP-E also stated R2 should wait 5 minutes before the second inhaler. When asked if R2 waited in between puffs and between inhalers, ULP-E stated, "I guess she did," and said R2 knew she needed to do that. The surveyor also asked if they were told R2 needed to rinse and spit, ULP-E stated R2 always refused to rinse and spit and would want to eat but had given reminders. During phone interview on August 27, 2026, at 11:08 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to administer the first inhaler ensuring 30-60 seconds in between puffs then wait 15 minutes or so in between inhalers. CNS-B later stated time between inhalers required 10 minutes and they were aware inhalers with steroids required a swish and spit which R2 did at the beginning but R2 was not always compliant. CNS-B stated they would schedule the inhaler at different times on the MAR to avoid them being administered right after each other. CNS-B acknowledged R2's record did not include inhaler administration instructions but said staff had been trained. Spiriva Respimat manufacturer instructions revised January 2025, instructed to breathe out	02320		

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02320	Continued From page 73 slowly and fully, close lips around mouthpiece and while taking a slow, deep breath through the mouth and press the dose-release button and continue to breathe in. Hold breath for 10 seconds or for as long as comfortable. Dulera manufacturer instructions dated December 2025, instructed to breathe out slowly and fully, close lips around mouthpiece and while taking a slow, deep breath through the mouth and press the dose-release button and continue to breathe in. Hold breath for 10 seconds or for as long as comfortable. Wait at least 30 seconds to take the second puff. After administration, rinse mouth with water and spit out the water. Do not swallow it. The licensee's 7.35 Inhaler policy effective October 11, 2021, indicated only properly trained staff may provide medication assistance or administration. Inhaler medications must be administered according to the prescribers' orders and verified with the manufacture's requirements per instructions. Inhaler procedure were as follows: -instruct the resident to take a breath and let it out, begin to breathe in slowly, and then compress the inhaler to release the medication. Hold breath for 5-10 seconds to allow medication to reach deeply into lungs; -wait at least 1 minute in between puffs of same medication; -wait at least 5 minutes before administering different inhaled medications; and -provide resident the opportunity to rinse out mouth. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02320		

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02320	Continued From page 74 days	02320		
02330 SS=D	144G.91 Subd. 5 Refusal of care or services Residents have the right to refuse care or assisted living services and to be informed by the facility of the medical, health-related, or psychological consequences of refusing care or services. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document any efforts to educate a resident who was repeatedly refusing a medication ordered by a prescriber for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 24, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included chronic obstructive pulmonary disease (COPD- difficulty breathing), chronic pain, elevated blood pressure, and major depressive disorder.	02330		

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02330	Continued From page 75 R2's Service Plan (Waiver) - Addendum to Contract effective April 21, 2025, indicated R2 received services such as with bathing, behavior management, dressing, housekeeping, medication administration, and oxygen delivery. R2's current Assessment by Date completed remotely by CNS-B on June 15, 2026, indicated R2 required assistance with medication administration and used gabapentin for hip and knee pain. R2's provider orders signed January 7, 2025, ordered gabapentin 400 mg (milligram), one capsule three times daily for nerve pain. During observation on August 25, 2026, at 8:10 a.m., unlicensed personnel (ULP)-E set up R2 oral medications: acetaminophen 500 mg, one tablet (for pain); duloxetine 30 mg extended release, one capsule (for depression); furosemide 40 mg, one tablet (treats fluid retention); methocarbamol 500 mg, one tablet (relieves acute musculoskeletal pain); and vitamin D3 25 mcg (microgram), one tablet (supplement). ULP-E asked R2 if she wanted her gabapentin, R2 stated no so it was not set up. ULP-E stated to the surveyor R2 had been refusing gabapentin for a month. R2 stated the gabapentin upset her stomach. R2 then took her oral medications. R2's medication administration record (MAR) dated July 2026, indicated the following: -gabapentin 300 mg capsule, take two (2) capsules (600 mg total) by mouth three (3) times daily (92 out of 93 doses were refused, one dose given) (record did not have current provider order).	02330		

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02330	Continued From page 76 R2's MAR dated August 2026, indicated the following: -gabapentin 300 mg capsule, take two (2) capsules (600 mg total) by mouth three times daily (68 out of 70 doses were refused, one dose undocumented, and one dose given) (record did not have current provider order). During interview on August 25, 2026, at 3:00 p.m., owner/registered nurse (O/RN)-A stated they were not aware R2 had been refusing her gabapentin. The surveyor and O/RN-A went to observe R2's gabapentin bubble pack where the afternoon and bedtime packs were dispensed March 2026 indicating they had not been refilled for several months. On August 26, 2026, at 2:18 p.m., via email, CNS-B indicated they were aware R2 had been refusing the gabapentin and it was reported to the primary provider's nurse and the nurse would discontinue it if R2 went in for an appointment. R2 declined an in person appointment as she referred phone appointments. CNS-A was asked if there was documentation of the above conversation with CNS-B and the clinic, CNS-B indicated they would go back into their notes and look. R2's most recent nursing visit note completed by CNS-B on August 9, 2026, indicated CNS-B completed a routine nursing visit with R2 and R2 had been compliant with her prescribed medications and facility rules. No medication concerns or adverse effects were reported. CNS-B also indicated they provided routine nursing education and encouraged R2 to continue complying with her mediations and to notify staff or the nurse of any changes in condition, medication concerns, or other	02330		

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02330	Continued From page 77 healthcare needs. R2 verbalized understanding. No new nursing concerns were identified during the visit. R2's nursing note completed by CNS-B on July 20, 2026, indicated they contacted R2's primary care provider's office to report R2's ongoing knee pain and request for medication review. CNS-B had requested the as needed (PRN) Tylenol be scheduled due to consistent use the last 2-3 months and requested an order. The note did not mention anything about R2's gabapentin refusal. R2's record lacked documentation R2 was informed by the facility of the medical and health related consequences of refusing care or services. The licensee 7.22 Medication & Treatment Record-Documentation & Refusal policy effective October 11, 2021, indicated if a medication was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. The licensee would document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02330		

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

Food & Beverage Inspection Report

Establishment Info

The Beatitudes Homes
3812 Commodore Dr
Brooklyn Park, MN 55444
Hennepin County
Parcel:

Phone:
sonie22cutie@gmail.com

License Info

License: HFID 36744

Risk:
License:
Expires on:
CFPM: Sonie Padmore
CFPM #: 119401; Exp: 9/26/2026

Inspection Info

Report Number: F1031261256
Inspection Type: Full - Single
Date: 8/24/2026 Time: 12pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 5
Total Priority 3 Orders: 6
Delivery: Emailed

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT:
OBSERVED OPEN PACKAGE OF RAW BACON STORED ON TOP OF OPEN PACKAGE OF RAW DELI MEAT.

DELI MEAT DISCARDED.

DISCUSSED PROPER STORAGE OF RAW ITEMS WITH PIC AND HAD PIC MOVE ITEMS IN REFRIGERATOR.

REFRIGERATOR STORAGE DIAGRAM SENT WITH REPORT.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 3-500A Microbial Control: cooling
3-501.13ABC *Priority Level: Priority 3 CFP#: 35*
MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.
COMMENT:
STAFF THAWING FOODS IN AMBIENT TEMPERATURES.
DISCUSSED THAWING WITH PIC AND INFORMED HER OF 3 THAWING OPTIONS.
DISCONTINUE THAWING IN AMBIENT TEMPS AND USE APPROVED THAW METHOD LISTED ABOVE.

Comply By: 8/28/2026 Originally Issued On: 8/24/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT:
DELI MEAT AND MILK IN REFRIGERATOR MEASURED 50, 47F.

ALL TCS ITEMS IN REFRIGERATOR DISCARDED.

DISCONTINUE USE OF REFRIGERATOR UNTIL REPAIRED OR REPLACED.
Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT:
FACILITY IS NOT DATE MARKING REQUIRED ITEMS.
BEGIN DATE MARKING IMMEDIATELY.
DISCARD ANY ITEMS DATE MARKED AFTER 7 DAYS.

Comply By: 8/28/2026 Originally Issued On: 8/24/2026

! **New Order: 3-700 Contaminated Food: discarded**
3-701.11A *Priority Level: Priority 1 CFP#: 17*
MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.
COMMENT:
OBSERVED ROTTEN ONIONS IN LOWER CUPBOARD BY OVEN.

ONIONS DISCARDED

KEEP ALL FOODS STORED IN COMMON PLACED SO NO FOODS ARE FORGOTTEN.

CHECK FOODS FOR ROT/MOLD ON DAILY BASIS.
Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 4-300 Equipment Numbers and Capacities
4-301.12A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.
COMMENT:
FACILITY DOES NOT HAVE 3-COMP SINK OR DISH MACHINE.
INSTALL 3-COMP SINK OR DISH MACHINE.

CONTACT INSPECTOR ONCE INSTALLED.
Comply By: 8/28/2026 Originally Issued On: 8/24/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT:
ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 8/28/2026 Originally Issued On: 8/24/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT:
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.
SANI TEST STRIPS LEFT ON SITE.
PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT) ON REGULAR BASIS.

Comply By: 8/28/2026 Originally Issued On: 8/24/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT:
1. KITCHEN REFRIGERATOR IS NOT KEEPING FOOD 41F OR BELOW.
STAFF REARRANGED REFRIGERATOR AND THERMOMETER PICTURE SUBMITTED 8/25 MEASURED 41F.

MONITOR TEMPS WITH THIN PROBE THERMOMETER.
REPAIR/REPLACE REFRIGERATOR AS NEEDED.

2. 2-COMP SINK FAUCET IS NOT PROPERLY ATTACHED TO SINK BASIN.
REATTACH FAUCET. REPLACE FAUCET IF UNABLE TO SECURELY REATTACH.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT:

HANDWASH BLOCKED BY UTENSILS IN BASIN,
HAD PIC REMOVE ITEMS IN BASIN.
KEEP HANDWASH SINK CLEAR AT ALL TIMES.

Comply By: 8/26/2026 Originally Issued On: 8/24/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT:
HANDWASH REMINDER SIGN MISSING FROM HANDWASH STATION.
COPY OF REMINDER SIGN SENT WITH REPORT.
PRINT AND POST SIGN OR PURCHASE SIMILAR.

Comply By: 9/21/2026 Originally Issued On: 8/24/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT:
MULTIPLE CUPBOARDS HAVE ROUGH SURFACES THAT ARE NO LONGER SMOOTH DURABLE, EASILY CLEANABLE, AND NON-ABSORBENT.

CLEAN INTERIOR OF CUPBOARDS AND COVER ANY ROUGH/UNCLEANABLE SURFACES WITH CONTACT PAPER OR SIMILAR.

Comply By: 9/21/2026 Originally Issued On: 8/24/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.111ABD *Priority Level: Priority 3 CFP#: 38*
MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.
COMMENT:
OBSERVED MULTIPLE ANTS CRAWLING ON CABINETRY TO RIGHT OF REFRIGERATOR.
WORK WITH PEST CONTROL OR OTHER TO ELIMINATE PESTS FROM FACILITY.

Comply By: 9/21/2026 Originally Issued On: 8/24/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT:
THE FOLLOWING AREAS NEED TO BE THOROUGHLY CLEANED:

1. LOWER ONION CUPBOARD BY STOVE.
2. BASEBOARDS AROUND KITCHEN.
3. ALL CUPBAORDS INTERIORS, EXTERIORS, AND HANDLES.
4. BACK KITCHEN WALL.

Comply By: 9/21/2026 Originally Issued On: 8/24/2026

Food & Beverage General Comment

Nurse Evaluator on site: Anna Bohnen

All violations discussed with PIC during the inspection.

NOTES:
Facility has a residential kitchen with the following finishes:
Laminate flooring
Wood cabinetry
Laminate countertops
Tile backsplash
Textured ceiling
2-comp sink with one basin designated for handwashing.

Since establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

Discussed the following with pic:
Hand washing
Ware washing and dish machine temp (160F or greater)
Illness and illness log
No undercooked foods and cooking temps
Pasteurized egg use

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 F1031261256 from 8/24/2026

Sonie Padmore
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

The Beatitudes Homes
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1031261256
Inspection Type: Full
Date: 8/24/2026
Time: 12pm

Food Temperature: Product/Item/Unit: Deli Meat**; Temperature Process:** Cold-Holding
Location: Refrigerator at 50 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 47 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Salad**; Temperature Process:** Cold-Holding
Location: Refrigerator at 47 Degrees F.
Comment:
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: Thermometer**; Temperature Process:** Ambient Air
Location: Refrigerator (door) Next Day at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

The Beatitudes Homes
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1031261256
Inspection Type: Full
Date: 8/24/2026
Time: 12pm

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Pre-Soaked Towelettes
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36744016-0	**Date:** August 25, 2026
Facility Name: THE BEATITUDES HOMES LL	
Facility Address: 3812 Commodore Dr, Minneapolis, Minnesota 55429	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Emergency escape and rescue openings. Required emergency escape and rescue openings shall be operational from the inside of the room without the use of keys or tools. Bars, grilles, grates or similar devices are allowed to be placed over emergency escape and rescue openings provided the minimum net clear opening size complies with this code and such devices shall be releasable or removable from the inside without the use of a key, tool, or force greater than that which is required for normal operation of the escape and rescue opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.7]

   Comments: The licensee failed to maintain the required emergency escape and rescue opening in an operable condition. The egress window in Resident Room 4 was broken and could not be opened properly. Licensed assisted living director (LALD)-C attempted to try and open the window but stated he was unable to. The damaged window prevented the emergency escape and rescue opening from being readily operable, potentially delaying or preventing emergency evacuation from the resident room. No residents currently occupying the room since June of 2026.

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

   Comments: The dryer exhaust vent was detached from the dryer and there was excessive lint/debris accumulation behind the machine posing a fire hazard.

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

   Comments: Licensee failed to provide proper protection against carbon monoxide. Only one carbon monoxide alarm was located within the facility basement living room. No carbon monoxide detector was located on the upper level or adjacent to the upper-level rooms.

☒ **TAG IDENTIFICATION: 0780**

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

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1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: Inside resident room 4 the smoke alarm was missing from the bracket. LALD-C stated the pervious resident moved out in June of 2026, and they were unable to locate the smoke alarm. Even if no residents are occupying the bedroom a smoke alarm is still required to provide life safety coverage for all residents and staff.

☒ **TAG IDENTIFICATION: 0790**

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

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

   Comments: The licensee failed to properly maintain their fire extinguishers. No annual service had been completed since March of 2024 and no monthly checks of the extinguishers were documented.

☒ **TAG IDENTIFICATION: 0800**

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

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

   Comments:

- *Upstairs resident bathroom floor tiles were missing and broken, allowing water to possibly penetrate as well as a tripping concern for residents and staff.*

- *Basement walls were missing trim boards.*

- *Upstairs walls showed extensive damage to sheetrock and door trim.*

☒ **TAG IDENTIFICATION: 0810**

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

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD-C could not provide a resident policy that was readily available for all staff and residents. LALD-C did provide resident policy located in a computer document which was not accessible by everyone.

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

   Comments: Labels identifying rooms three and four were not identified on or adjacent to the physical door. This could result in confusion and safety concerns in the event of an emergency.

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

   Comments: The licensee's FSEP failed to outline employee procedures in the event of a fire. LALD-C provided multiple policies within the emergency binder which could lead to confusion among staff. Policies also mentioned the use of smoke compartments which the facility was not equipped with. The FSEP should accurately reflect the facility layout and fire protection systems equipment within.