Electronically Delivered

October 14, 2026

Licensee
Twin Cities Living Assistance LLC
12920 Highclere Drive
Burnsville, MN 55337

RE: Project Number(s) SL41508015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 23, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. 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 - 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

The total amount you are assessed is $1,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health 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 MDH 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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	41508	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES LIVING ASSISTANCE LLC	12920 HIGHCLERE DR BURNSVILLE, MN 55337

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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: SL41508015-0 On September 21, 2026, through September 23, 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 four resident(s); four receiving services under the provisional 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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan included the required content according to MN Rules 4659.0180, Subp. 4, potentially affecting the licensee's residents, staff, and any visitors of the licensee.	0 470		

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held a provisional assisted living license and was licensed for a capacity of five residents with a current census of four residents. On September 21, 2026, at 11:30 a.m. during entrance conference, licensed assisted living director (LALD)-A stated the licensee staffed each shift with one unlicensed personnel with the availability of additional staff as needed for outside the facility activities/shopping. The surveyor requested the licensee's staffing plan. Clinical nurse supervisor (CNS)-B stated the plan was posted by the workstation in the facility living room area. On September 21, 2026, at 12:30 p.m., the surveyor observed an undated document on the bulletin board by the desk in the living room labeled "Facility Staffing Plan" and indicated days of the week to be "Sunday to Sunday", shifts listed as "1st, 2nd, 3rd" and a third column designed to include the number of staff; however, that column included the hours for each shift "8:00 a.m.-2:00 p.m., 2:00 p.m.-10:00 p.m., and 10:00 p.m.-8:00 a.m.), and lacked an indication of the number of staff planned for each shift (day/evening/overnight).	0 470		

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0 470	Continued From page 3 The licensee failed to develop and implement a staffing plan for determining its staffing level, that is for each shift. The licensee's Staffing policy dated November 13, 2025, indicated the plan considers the number of qualified direct-care staff (home health aides) to meet the residents' needs throughout the day and night. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 4 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (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	0 480		

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0 480	Continued From page 5 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 22, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the	0 485		

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0 485	Continued From page 6 resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents in the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 21, 2026, at 12:30 p.m. during facility tour, the surveyor observed unlicensed personnel (ULP)-D preparing a resident's lunch in the kitchen. The surveyor did not observe a menu posted and available. ULP-D stated they used to have a two week menu posted but had not been using it, so it was taken down. The She further stated the licensee often made meals per resident choices/preferences. The licensee failed to post a menu a week in advance as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		

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0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 21, 2026, at 11:30 a.m. during the entrance conference, licensed assisted living	0 580		

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0 580	Continued From page 8 director (LALD)-A stated he only recently taken over the LALD duties for the facility and was not certain about the facility's plan but would look for it. At 12:30 p.m., LALD-A stated he could not find any evidence a quality management plan had been developed. Clinical nurse supervisor (CNS)-B also stated he was new to the facility only a couple months ago and was not aware of a plan. The licensee's Quality Management Program policy dated November 13, 2025, indicated has established a quality improvement program based on the organization's size and appropriate to the type of services provided to ensure that effective, comprehensive and appropriate plans are operational for all residents within the organization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to assisted living services on February 4, 2026, with diagnoses including hypertension, malnutrition, and chronic pain. R1's Addendum to Contract-Waiver-MN (used as the Service Plan) dated February 5, 2026, indicated he received services including medication reminders, assistance with bathing, grooming, toileting reminders, laundry and housekeeping. Although receiving medication services, R1's service plan did not include the services of medication management/administration, medication set up, and behavior management). On September 22, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D review R1's medication administration record (MAR) dated September 2026, identified four oral	0 630		

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0 630	Continued From page 10 medications found in R1's pill minder box, one oral medication from a bubble pack, selected a protein drink from the refrigerator and administered them to R1 in his room. R1's IAPP (included in his comprehensive assessment) dated September 17, 2026, included his susceptibility to abuse from others and included interventions to minimize his risk for abuse; however, R1's IAPP lacked the required content indicating his susceptibility to abuse others and interventions to minimize risks to others as indicated. R2 R2 was admitted to assisted living services on August 21, 2026, with diagnoses including bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, and schizoaffective disorder. R2's Assisted Living Service Agreement dated August 31, 2026, indicated medication management/administration, behavioral support for agitation, anxiety, self-isolation and verbal aggression, meals, and routine safety checks. On September 21, 2026, at 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-D interact with R2 in R2's room. R2's IAPP (included in her comprehensive assessment) dated September 6, 2026, included her susceptibility to abuse from others and included interventions to minimize her risk for abuse; however, R2's IAPP lacked the required content indicating her susceptibility to abuse others and interventions to minimize risks to others as indicated.	0 630		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 630	Continued From page 11 R3 R3 was admitted to assisted living services on April 14, 2026. R3's Assisted Living Service Agreement dated April 14, 2026, indicated the facility shall provide assistance with health-related needs as applicable to the resident's care plan, including medication management including administration of daily and as needed medications, behavioral support to agitation anxiety, self-isolation and verbal aggression, ongoing monitoring of mental health symptoms, meal preparation, routine safety checks, housekeeping, transportation, and social and recreational activities. On September 21, 2026, at 12:15 p.m. the surveyor observed unlicensed personnel (ULP)-D interact with R3 in his room. R3's IAPP (included in his comprehensive assessment) dated September 19, 2026, included his susceptibility to abuse from others and interventions to minimize his risk for abuse; however, R3's IAPP lacked the required content indicating his susceptibility to abuse others and interventions to minimize risks to others as indicated. R4 R4 was admitted to assisted living services on June 24, 2026. R4's Service Plan dated June 23, 2026, indicated she received assistance with behavior management, safety checks, meals, housekeeping and laundry. On September 22, 2026, at 10:00 a.m., the surveyor observed unlicensed personnel	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41508	A. BUILDING: _____ B. WING _____	09/23/2026

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0 630	Continued From page 12 complete a safety check and serve breakfast to R4 in her room. R4's IAPP (included in her comprehensive assessment) dated September 17, 2026, susceptibility to abuse from others and included interventions to minimize her risk for abuse; however, R2's IAPP lacked the required content indicating her susceptibility to abuse others and interventions to minimize risks to others as indicated. The licensee failed to include R1, R2, R3, R4's susceptibility to abuse others including other vulnerable adults, and failed to include interventions to minimize their risk to others, if needed. On September 23, 2026, at 10:40 a.m., clinical nurse supervisor (CNS)-B stated he was not aware that IAPP required the statement reflecting the residents' susceptibility to abuse others even if he determined they were not a threat to others. The licensee's Individual Abuse Plans policy dated November 13, 2025, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. The plan shall contain the risk of abusing other vulnerable adults, and the plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided.	0 630		

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0 630	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	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 contained the required content for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650		

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0 650	Continued From page 14 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on July 2, 2026, to provide direct care services to the licensee's residents. On September 22, 2026, at 8:05 a.m., the surveyor observed ULP-D administer oral medications to R1. ULP-D stated the facility's registered nurse (RN) had provided medication training and competency when she was hired and she remembered that clinical nurse supervisor (CNS)-B had watched her pass medications again a few weeks later; however, she could not remember the exact date. ULP-D's employee record lacked evidence of documentation of a 30-day RN supervision evaluation. On September 23, 2026, at 11:10 a.m., CNS-B stated he had observed ULP-D within 30 days after she was first trained and then on an ongoing basis thereafter; however, he did not document any of those follow up RN observations. The licensee's Personnel Records policy dated November 13, 2025, at a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements would include competency evaluations.	0 650		

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0 650	Continued From page 15 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 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a TB facility risk assessment and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 16 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: FACILITY RISK ASSESSMENT On September 21, 2026, at 11:30 a.m. during entrance conference, the surveyor requested the facility's TB risk assessment. On September 21, 2026, at 2:00 p.m., licensed assisted living director (LALD)-A stated he had recently taken over LALD duties and was unable to locate a TB facility risk assessment. TB TESTING ULP-D ULP-D's employee record indicated a hire date of July 2, 2026, to provide direct care services to the licensee's residents. ULP-D's record included a TB symptom screening dated July 2, 2026, and a first step TST dated July 6, 2026; however, there was no evidence a second step TST was completed as required. On September 22, 2026, at 11:15 a.m., LALD-A stated ULP-D missed her appointment for her second TST and never rescheduled it. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July	0 660		

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0 660	Continued From page 17 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the health care worker (HCW) starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening Prevention policy dated November 13, 2025, indicated the Director is responsible for conducting the TB Risk Assessment annually using the MDH Risk assessment worksheet to determine the TB risk associated with the agency's population. Additionally, baseline testing is completed on hire for all direct care providers and anyone who visits residents (including volunteers). 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:	0 680		

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0 680	Continued From page 18 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 680		

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0 680	Continued From page 19 portion or all the residents). The findings include: The licensee's emergency preparedness plan last reviewed February 20, 2026, lacked the following required content: - Subsistence Needs for Staff and Residents- the plan lacked policies and procedures to provide for adequate subsistence for all residents and staff for the duration of an emergency, addressing food, water, medical and pharmaceutical supplies, alternative sources of energy, sewage, and waste disposal was incomplete and lacked what the supplies were and where they could be found - Resident population-the plan lacked resident information and their needs in an evacuation. The EP plan included delegations of authority and succession plan; however, the names/contact information was not current - Evacuation policy and procedure lacked an indication regarding how residents would be transported in the event of an evacuation - Medical Documents - Policy and Procedure-the plan lacked a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains availability of records - Volunteers - Policy and Procedure-the plan lacked an indication of any volunteer policy procedure - Names and Contact Information - Communication Plan -The facility's communication plan lacked contact information for staff and residents' providers, family/guardian/case manager contact information - Sharing Information on Occupancy/Needs-The plan lacked documentation of a means of	0 680		

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0 680	Continued From page 20 providing information about the facility's occupancy, needs, and its ability to aid, to the authority having jurisdiction, the Incident Command Center, or designee. - The Missing Resident Plan was not part of the EP plan and had not been reviewed on a quarterly basis. On September 23, 2026, at 2:00 p.m., licensed assisted living director (LALD)-A, reviewed the facility's Disaster Plan with the surveyor and stated the plan was purchased and had much of what was needed; however, some areas of the plan needed to be tailored for the facility and more clarification and detail was needed to parts of the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	0 730		

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0 730	Continued From page 21 records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee's records included the required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a	0 730		

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0 730	Continued From page 22 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to assisted living services on February 4, 2026, with diagnoses including hypertension, malnutrition, and chronic pain. R1's Addendum to Contract-Waiver-MN (used as the Service Plan) dated February 5, 2026, indicated he received services including medication reminders, assistance with bathing, grooming, toileting reminders, laundry and housekeeping. Although receiving medication services, R1's Service Plan lacked the services of medication management/administration, medication set up, and behavior management). On September 22, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D review R1's medication administration record (MAR) dated September 2026, identified four oral medications found in R1's pill minder box, one oral medication from a bubble pack, selected a protein drink from the refrigerator and administered them to R1 in his room. R2 R2 was admitted to assisted living services on August 21, 2026, with diagnoses including bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, and	0 730		

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0 730	Continued From page 23 schizoaffective disorder. R2's Assisted Living Service Agreement dated August 31, 2026, indicated medication management/administration, behavioral support for agitation, anxiety, self-isolation and verbal aggression, meals, and routine safety checks. On September 21, 2026, at 12:00 p.m., the surveyor observed ULP-D interact with R2 in R2's room. R3 R3 was admitted to assisted living services on April 14, 2026. R3's Assisted Living Service Agreement dated April 14, 2026, indicated the facility shall provide assistance with health-related needs as applicable to the resident's care plan, including medication management including administration of daily and as needed medications, behavioral support to agitation anxiety, self-isolation and verbal aggression, ongoing monitoring of mental health symptoms, meal preparation, routine safety checks, housekeeping, transportation, and social and recreational activities. On September 21, 2026, at 12:15 p.m. the surveyor observed ULP-D interact with R3 in his room. R4 R4 was admitted to assisted living services on June 24, 2026. R4's Service Plan dated June 23, 2026, indicated she received assistance with behavior management, safety checks, meals, housekeeping and laundry.	0 730		

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0 730	Continued From page 24 On September 22, 2026, at 10:00 a.m., the surveyor observed ULP-D complete a safety check and serve breakfast to R4 in her room. R1, R2, R3, and R4's resident profiles lacked names, addresses and telephone numbers of emergency contacts and family members or responsible parties, names and addresses and telephone numbers of the resident's legal representative and designated representatives, hospital preference, provider contact information. In addition, R2 and R4 resident profiles lacked their diagnoses. On September 23, 2026, at 11:10 a.m., clinical nurse supervisor (CNS)-B stated he had taken over the CNS duties a couple months before and was still working through getting things caught up. He stated he had not noted the resident profiles were missing the required content. The licensee's Clinical Records policy dated November 13, 2025, indicated the clinical record contains the following information: - Resident's name - Address - Telephone number - Date of birth - Admission/discharge dates - Names, addresses and telephone numbers of emergency contact and family members or responsible parties - Names, addresses and telephone numbers of the residents' legal representatives and designated representatives No further information provided. TIME PERIOD FOR CORRECTIONS:	0 730		

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0 730	Continued From page 25 Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to 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	0 780		

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TWIN CITIES LIVING ASSISTANCE LLC	12920 HIGHCLERE DR BURNSVILLE, MN 55337

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0 780	Continued From page 26 compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 27 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 28 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 23, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060		

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01060	Continued From page 29 may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one resident of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 was admitted to assisted living services on June 24, 2026.	01060		

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01060	Continued From page 30 R4's Service Plan dated June 23, 2026, indicated she received assistance with behavior management, safety checks, meals, housekeeping and laundry. R4's record included an after-visit summary (AVS) dated August 16, 2026, which indicated R4 was hospitalized from August 9, 2026, until August 16, 2026, for symptom management and newly acquired deep vein thrombosis (blood clot) in the upper right arm. R4's Resident Notes dated: - August 9, 2026, indicated R4 was sent to the emergency department after continued complaints of abdominal pain, vomiting, nausea and diarrhea with newly developed hypotension (low blood pressure); and - August 16, 2026, indicated R4 returned to the facility with medication changes after a newly diagnosed deep vein thrombosis. R4's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an	01060		

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01060	Continued From page 31 appeal. In addition, R4's records lacked notification to the Office of Ombudsman for Long-Term Care, the resident had been relocated and had not returned to the facility within four days. On September 23, 2026, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated he was not aware of the requirement for the emergency relocation notice and notification of the Ombudsman and had not completed the written notice nor contacted the Ombudsman. The licensee's Discharge and Transfer of Residents policy dated November 13, 2025, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: - the resident - the resident's legal representative - the resident's designated representative - if the resident receives home and community-based services, the resident's case manager - if the resident has been relocated and not returned to Garden View Home Health within four (4) days, the Office of Ombudsman for Long-Term Care - notice of the right to appeal the decision under 144G.54 Additionally, the written notice shall include the following: - the reason for the relocation - name and contact information for the location to which the resident has been located and any new service provider - contact information for the Office of	01060		

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01060	Continued From page 32 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities - if known, the approximate date range within which the resident is expected to return to the facility or a statement that the date is not currently known - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has a right to appeal the decision and contact information for the person to whom the resident should submit the appeal. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01470		

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01470	Continued From page 33 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 34 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of four unlicensed personnel (ULP-D, ULP-E) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired on July 2, 2026, to provide direct care services to the licensee's residents. ULP-D's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff	01470		

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01470	Continued From page 35 responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure ULP-E ULP-E was hired on April 21, 2026 , to provide direct care services to the licensee's residents. ULP-E's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470		

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01470	Continued From page 36 and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure On September 23, 2026, at 11:15 a.m., licensed assisted living director (LALD)-A stated that both ULP-D and ULP-E were enrolled in the licensee's online training program which included all the required orientation training courses. ULP-D had started some courses but had not completed them. ULP-E had worked at an assisted living facility months before she was hired by the licensee and had evidence of her orientation training. LALD-A stated he thought the orientation training was transferable between assisted living facilities as long as it was within a certain period and stated he was not aware that the orientation training topics were facility specific training courses and not transferred unless owned by the same agency. The licensee's Orientation and Education policy dated November 13, 2025, indicated orientation topics will include, but not be limited to, the following:	01470		

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01470	Continued From page 37 a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 b. Review of the employee's job description and responsibilities c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that any act that constitutes maltreatment is prohibited f. The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff h. Grievance Policy/Process, including reports to the Office of Health Facility Complaints i. Consumer advocacy services, including No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia	01530		

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01530	Continued From page 38 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care	01530		

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01530	Continued From page 39 staff received the required amount of dementia care training in the required time frame for one of four unlicensed personnel (ULP-D). Furthermore, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date for one of two employees (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held a Provisional Assisted Living License with an expiration date of February 6, 2026. ULP-D was hired on July 2, 2026, to provide direct care services to the licensee's assisted living residents. On September 22, 2026, at 8:05 a.m., the surveyor observed ULP-D set up and administer oral medications to R1. ULP-D's employee file/Residex training transcript printed September 22, 2026, indicated she was enrolled in dementia and mental health training courses; however, had not completed them. On September 22, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A stated ULP-D	01530		

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01530	Continued From page 40 was assigned the required courses; however, she had not completed them. He further stated ULP-D had worked greater than 160 hours since her employment started. The licensee's Education on Dementia training policy dated November 13, 2025, indicated direct care employees must have completed at least eight (8) hours of initial education** within 160 working hours of the employment start date. The licensee's Education on Mental Illness and De-escalation policy dated November 13, 2025, indicated direct care employees must have completed at least two (2) hours of initial education** within 160 working hours of the employment start date in the following topics: a Recognizing symptom of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; b. De-escalation techniques and communication; and c. Crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	01620		

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01620	Continued From page 41 living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part 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	01620		

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01620	Continued From page 42 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 not to exceed 90 days for one of four residents (R1). In addition, the RN failed to complete a comprehensive assessment for a change in condition for one of one resident (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 21, 2026, at 11:15 a.m. during entrance conference, clinical nurse supervisor (CNS)-B stated he understood the RN assessment schedule to be: prior to admission, day of admission, 14 days following admission, every 90 days, and with a change in condition. 90 DAY ASSESSMENT R1 was admitted to assisted living services on	01620		

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01620	Continued From page 43 February 4, 2026, with diagnoses including hypertension, malnutrition, and chronic pain. R1's Addendum to Contract-Waiver-MN (used as the Service Plan) dated February 5, 2026, indicated he received services including medication reminders, assistance with bathing, grooming, toileting reminders, laundry and housekeeping. Although R1 received medication services, R1's Service Plan lacked the services of medication management/administration, medication set up, and behavior management). On September 22, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D review R1's medication administration record (MAR) dated September 2026, identified four oral medications found in R1's pill minder box, one oral medication from a bubble pack, selected a protein drink from the refrigerator and administered them to R1 in his room. R1's comprehensive assessments since admission were requested. Resident evaluations dated January 17, 2026 (preadmission), February 17, 2026 (14 day), June 1, 2026, and September 17, 2026, were provided. June 1, 2026, assessment was 117 days after the previous assessment date, thus exceeding 90 calendar days. On September 23, 2026, at 11:10 a.m., CNS-B stated the previous nurse would have managed the assessments during this time, and he could not speak to the timeline of that assessment. ASSESSMENT FOR CHANGE IN CONDITION R4 was admitted to assisted living services on June 24, 2026.	01620		

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01620	Continued From page 44 R4's Service Plan dated June 23, 2026, indicated she received assistance with behavior management, safety checks, meals, housekeeping and laundry. On September 22, 2026, at 10:00 a.m., the surveyor observed ULP-D complete a safety check and serve breakfast to R4 in her room. R4's record included an after-visit summary (AVS) dated August 16, 2026, which indicated R4 was hospitalized from August 9, 2026, until August 16, 2026, for symptom management and a newly acquired deep vein thrombosis (blood clot) in the upper right arm. R4's Resident Notes dated: - August 9, 2026, indicated R4 was sent to the emergency department after continued complaints of abdominal pain, vomiting, nausea and diarrhea with newly developed hypotension (low blood pressure); and - August 16, 2026, indicated R4 returned to the facility with medication changes, new discharge instructions and a newly diagnosed deep vein thrombosis. R4's comprehensive assessments since admission were requested. Resident assessments dated June 12, 2026 (pre-admission), June 24, 2026 (admission), and June 28, 2026 (14 day), and September 17, 2026, were received. R4's record lacked an RN assessment for a change in condition following her hospitalization in August 2026. The licensee failed to complete a comprehensive RN assessment for a change in condition following R4's hospitalization.	01620		

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01620	Continued From page 45 On September 23, 2026, at 10:00 a.m., CNS-B stated he wrote a very descriptive progress note upon R4's return to the facility; however, R4 is often resistant to being assessed and he did not complete a comprehensive RN assessment for a change in condition at that time. The licensee's Comprehensive Nursing Assessment and Reassessment policy dated November 13, 2025, indicated the RN will conduct and document a comprehensive assessment including day of admission, 14 days after services started, every 90 days and with a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility;	01650		

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01650	Continued From page 46 (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan accurately depicted the current services for one of four residents (R1). In addition, the licensee failed to ensure the service plan included all required content for three of four residents (R2, R3, R4) who received services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to assisted living services on February 4, 2026, with diagnoses including hypertension, malnutrition, and chronic pain.	01650		

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01650	Continued From page 47 R1's Addendum to Contract-Waiver-MN (used as the Service Plan) dated February 5, 2026, indicated R1 received services including medication reminders, assistance with bathing, grooming, toileting reminders, laundry and housekeeping. On September 22, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D review R1's medication administration record (MAR) dated September 2026, identified four oral medications found in R1's pill minder box, one oral medication from a bubble pack, selected a protein drink from the refrigerator and administered them to R1 in his room. R1's "Meds and Services Delivered" record used to show completed staff tasks dated September 2026, indicated staff completed the following tasks: -behavior management (anxiety, agitation, self-injurious, other mental health need); -meal preparation and serving -medication administration; -bathing assistance; -grooming; -light housekeeping; -laundry; -socialization; -ambulation; -toileting reminder R1's Service Plan lacked the services of medication management/administration, medication set up, and behavior management. R2 R2 was admitted to assisted living services on August 21, 2026, with diagnoses including bipolar disorder, generalized anxiety disorder,	01650		

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01650	Continued From page 48 post-traumatic stress disorder, and schizoaffective disorder. R2's Assisted Living Service Agreement dated August 31, 2026, indicated the facility shall provide assistance with health-related needs as applicable to the resident's care plan, including medication management including administration of daily and as needed medications, behavioral support to agitation anxiety, self-isolation and verbal aggression, ongoing monitoring of mental health symptoms, meal preparation, routine safety checks, housekeeping, transportation, and social and recreational activities medication management/administration, behavioral support for agitation, anxiety, self-isolation and verbal aggression, meals, and routine safety checks. On September 21, 2026, at 12:00 p.m., the surveyor observed ULP-D interact with R2 in R2's room. ULP-D stated the licensee provided medication administration of as needed (PRN) medications only for R2. R2's Meds and Services Delivered record dated September 2026, indicated staff completed tasks including: -managing behavior (agitation, anxiety, other mental health needs, self-isolation, verbal aggression); -meal preparation and service; -safety check; -socialization; and -bathing reminder R3 R3 was admitted to assisted living services on April 14, 2026. R3's Assisted Living Service Agreement dated	01650		

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01650	Continued From page 49 April 14, 2026, indicated the facility shall provide assistance with health-related needs as applicable to the resident's care plan, including medication management including administration of daily and as needed medications, behavioral support to agitation anxiety, self-isolation and verbal aggression, ongoing monitoring of mental health symptoms, meal preparation, routine safety checks, housekeeping, transportation, and social and recreational activities. On September 21, 2026, at 12:15 p.m., the surveyor observed ULP-D interact with R3 in his room. ULP-D stated R3 independently managed and self-administered his medications. R3's Meds and Services Delivered record dated September 2026, indicated staff completed tasks including: -manage behavior (agitation, other mental health needs, anxiety, verbal aggression, self-isolation); -meal preparation and serving; -socialization; and -safety check R4 R4 was admitted to assisted living services on June 24, 2026. R4's Assisted Living Service Agreement dated June 23, 2026, indicated the facility shall provide assistance with health-related needs as applicable to the resident's care plan, including medication management including administration of daily and as needed medications, behavioral support to agitation anxiety, self-isolation and verbal aggression, ongoing monitoring of mental health symptoms, meal preparation, routine safety checks, housekeeping, transportation, and social and recreational activities.	01650		

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01650	Continued From page 50 On September 22, 2026, at 10:00 a.m., the surveyor observed ULP-D complete a safety check and serve breakfast to R4 in her room. ULP-D stated R4 was independent with medication management and administration. R4's Meds and Services Delivered record dated September 2026, indicated staff completed tasks including: -manage behavior (agitation, anxiety, other mental health needs, self-isolation, verbal aggression); -meal preparation and serving; -light housekeeping; -bathing reminder; and -safety check R2, R3, and R4's Assisted Living Service Agreements were a standardized form that indicated the facility shall provide assistance with health-related needs as applicable to the resident's care plan including: - Medication management, including administration of scheduled and as-needed medications. - Bathing assistance (morning and evening) - Behavioral support for agitation, anxiety, self-isolation, and verbal aggression - Support and monitoring other identified mental health needs - Ongoing monitoring of mental health symptoms - Meal preparation and nutrition monitoring - Routine safety checks (day, evening, and overnight) - Light housekeeping (daily) - Bedmaking (daily) - Laundry services - Transportation assistance for medical and community needs	01650		

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01650	Continued From page 51 - Shopping assistance - Social and recreational activities R2, R3, R4's Service Plans were not individualized to their needs and lacked the required content including: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the residents; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On September 23, 2026, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated he understood the previous licensed assisted living director (LALD) created this particular Service Agreement and for some reason did not use the Service Agreement Addendum to the Contract found in	01650		

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01650	Continued From page 52 the licensee's Electronic Medical Record (EMR) system (Residex). Each Service Plan/Agreement within Residex was developed from the resident assessment and reflected the services. CNS-B stated the licensee used the proper Service Agreement/Plan for R1; however, he was not sure why a different form was used for the other residents. CNS-B stated he would review each resident record in the EMR, ensure all services were accurately depicted for each resident and work with the LALD to print and have them signed. Licensed assisted living director (LALD)-A stated the service plans for R2, R3, and R4 were developed prior to him taking on the duties of LALD at the facility and could not speak to the development or use of the current form. The licensee's Service Plan policy dated November 13, 2025, indicated an individualized service plan is implemented for all residents. [provider name] will provide all services required by the current service plan. The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party b. The fees for services and the frequency of each service, according to the residents' current review or assessment and resident preferences c. The identification of the staff or categories of staff who will provide the services d. The schedule and methods of monitoring reviews or assessments of the resident e. The schedule and method of monitoring staff providing services**. f. A contingency plan that includes the following i. Action to be taken if the scheduled service cannot be provided ii. Information and method for a resident or	01650		

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01650	Continued From page 53 resident's representative to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. The identification of and information as to who has the authority to sign for the resident in an emergency v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41508	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES LIVING ASSISTANCE LLC	12920 HIGHCLERE DR BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 54 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for the licensee's two residents (R1, R2) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41508	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES LIVING ASSISTANCE LLC	12920 HIGHCLERE DR BURNSVILLE, MN 55337

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01730	Continued From page 55 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to assisted living services on February 4, 2026, with diagnoses including hypertension, malnutrition, and chronic pain. R1's Addendum to Contract-Waiver-MN (used as the Service Plan) dated February 5, 2026, indicated he received services including medication reminders, assistance with bathing, grooming, toileting reminders, laundry and housekeeping. Although receiving assistance with medication management, R1's Service Plan lacked the services of medication management/administration, medication set up, as well as behavior management). On September 22, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D review R1's medication administration record (MAR) dated September 2026, identified four oral medications found in R1's pill minder box, one oral medication from a bubble pack, selected a protein drink from the refrigerator and administered them to R1 in his room. R1's medication administration record (MAR) dated September 2026, included one medication for cholesterol, one for high blood pressure, one for sleep, one for mild pain and three supplements. R1's Medication Management Plan dated September 17, 2026, indicated:	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41508	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES LIVING ASSISTANCE LLC	12920 HIGHCLERE DR BURNSVILLE, MN 55337

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01730	Continued From page 56 -R1 required medication management, administration and set up; -needed nurse instruction when medication changes occurred; -medication storage-medications were stored in a locked cabinet in pill packs -medications are documented and monitored through the electronic medication administration record (EMAR); -preferences in taking medications-resident prefers to take medications whole with water R1's Medication Management Plan lacked the required content including: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services R2 R2 was admitted to assisted living services on August 21, 2026, with diagnoses including bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, and schizoaffective disorder. R2's Assisted Living Service Agreement dated August 31, 2026, indicated medication management/administration, behavioral support for agitation, anxiety, self-isolation and verbal aggression, meals, and routine safety checks. On September 21, 2026, at 12:00 p.m., the surveyor observed ULP-D interact with R2 in R2's	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41508	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES LIVING ASSISTANCE LLC	12920 HIGHCLERE DR BURNSVILLE, MN 55337

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01730	Continued From page 57 room. ULP-D stated the licensee only stored and administered as needed (PRN) medications for R2. R2's MAR dated September 2026, included one medication for mild pain, one for muscle spasms, and one for nicotine withdrawal. R2's medication plan (found in the licensee's RN comprehensive assessment dated September 6, 2026), indicated: - R2 needed medication management and set up to ensure medications were taken correctly and safely as prescribed; - needs help with medication administration; - specific instructions relating to the administration, monitoring and documentation of medications-including the notes-staff should follow current prescriber orders/MAR, monitor adherence and report adverse effects, document medication administration as required, and promptly communicate medication concern or adverse effects to the prescribing provider. Medication reconciliation/prescriber review should be completed following admission R2's medication plan lacked the required content to include: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41508	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES LIVING ASSISTANCE LLC	12920 HIGHCLERE DR BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 58 services On September 23, 2026, at 11:10 a.m., clinical nurse supervisor (CNS)-B stated he thought the content was captured within the assessments/plans as required; however, he was uncertain what was required. The licensee's undated, Medication Management policy indicated for each resident receiving medication management services, an RN, APRN, or qualified staff delegated the task by an RN will prepare and include in the service plan a written statement of services. The current individualized medication management record will describe services provided; medication storage based on resident needs/preferences, diversion risk, and manufacturer directions; resident-specific administration instructions; persons responsible for monitoring supplies and timely refills; tasks delegated to unlicensed personnel; procedures for notifying the RN or appropriate licensed professional when problems arise; and resident-specific administration documentation, verification, and monitoring requirements. The record will be updated whenever changes occur. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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

TWIN CITIES LIVING ASSISTANCE
12920 HIGHCLERE DR
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

License Info

License: HFID 41508

Risk:
License:
Expires on:
CFPM: Caitlyn A. Lyons
CFPM #: CFPM-69498; Exp: 08/19/2029

Inspection Info

Report Number: F1005261240
Inspection Type: Full - Single
Date: 9/22/2026 Time: 10:10 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 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: RAW MEATS INCLUDING BACON, SAUSAGE, AND BEEF WERE STORED IN DRAWERS WITH READY-TO-EAT FOODS LIKE HOT DOGS AND DELI MEAT. STORE RAW ANIMAL FOODS BELOW READY-TO-EAT FOODS.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

New Order: 3-500C Microbial Control: date marking
3-501.17A *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.
COMMENT: OPENED PACKAGES OF READY-TO-EAT FOODS, INCLUDING DELI MEATS AND BOLOGNA, WERE NOT DATE MARKED. MARK THE DATE THAT READY-TO-EAT, TCS FOODS ARE OPENED TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS. FACT SHEET SENT WITH REPORT.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

Food & Beverage General Comment

INSPECTION COMPLETED WITH FOOD MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR DEBORAH JACOBSON.

FACILITY TESTS DISHWASHER TEMPERATURE DAILY AND KEEPS A LOG ON SITE. THE LOG SHOWS THAT THE DISHWASHER LABELS HAVE CONSISTENTLY BEEN HITTING THE MINIMUM OF 160 DEGREES F.

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

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

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

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

I acknowledge receipt of the Metro District Office inspection report number F1005261240 from 9/22/2026

CAITLYN LYONS
FOOD MANAGER

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41508015-0	**Date:** September 23, 2026
Facility Name: TWIN CITIES LIVING ASSISTANCE	
Facility Address: 12920 HIGHCLERE DR, Burnsville, MN, 55337	

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

   Comments: The existing hardwired smoke alarms were removed from the facility and replaced with battery powered smoke alarms. Existing hardwired smoke alarms are required to be maintained as installed previously and shall be replaced with smoke alarms having the same type of power supply.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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

Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

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

   Comments: The facility used an electronic care plan website for standard resident evacuation procedures. The FSEP didn't include standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensed assisted living director (LALD)-A failed to provide any record of staff training on the FSEP. Staff should be trained on the FSEP upon hire and at least twice a year thereafter.

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

   Comments: LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.

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

   Comments: LALD-A lacked documentation showing evacuation drills occurred twice per year, per shift, with at least one evacuation drill every other month. No other information or documentation was provided.