



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 30, 2025

Licensee
Happy Home LLC
6660 West 175th Avenue
Eden Prairie, MN 55346

RE: Project Number(s) SL25323016

Dear Licensee:

On October 20, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 6, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 6, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 6, 2025, found not corrected at the time of the October 20, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00
0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$3,000.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$1,000.00
0950-Designation Of Representative-144g.50 Subd. 3
1540-Training In Dementia, Mental Illness, And De--144g.64 (a) (3) - \$500.00
2060-Assisted Living Facilities With Dementia Care-144g.81 Subd. 3 - \$1,000.00

The details of the violations noted at the time of this follow-up survey completed on October 20, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on October 20, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$3,000.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$9,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject

to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Happy Home LLC. **Please contact Stephanie Jones de Palma, at 651-201-4320 on or before Monday January 5, 2026, to schedule the conference call.**

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink that reads "Stephanie Jones de Palma". The signature is fluid and cursive, with a large loop at the top of the first letter 'S'.

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Health Regulation Division
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25323	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/20/2025
NAME OF PROVIDER OR SUPPLIER HAPPY HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6660 WEST 175TH AVENUE EDEN PRAIRIE, MN 55346		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL25323016-1 On October 20, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 6, 2025. At the time of the survey, there were five residents; five receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 340 SS=L	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on August 6, 2025. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 340			

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0 340	Continued From page 2 a large portion or all of the residents). The findings include: On August 6, 2025, the Minnesota Department of Health (MHD) issued the following citations: 0470, 0480, 0650, 0660, 0680, 0775, 0780, 0790, 0810, 0830, 0950, 1370, 1380, 1460, 1540, 1770, 1820, 2040, 2060, 2310 and 3090. On October 20, 2025, MDH conducted a follow up survey and as a result the following citations were reissued: 0680, 0775, 0780, 0950, 1540, and 2060. On October 20, 2025, at 8:00 a.m., the licensee's plan of correction (POC) documentation was a printed copy of the survey results from MDH. For citation 0680 (emergency preparedness), there was a handwritten note that stated, "number added". For citation 0950 (verbatim language for designating a representative) the required language was, "verbatim language used and posted". For citation 1540 (mental illness and de-escalation) there was no written documentation of the actions taken to correct the citation. On October 20, 2025, at 1:38 p.m., and 1:58 p.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they were responsible for correcting the citations related to clinical aspects of the facility and co-owner (C/O)-F was responsible for citations related to the business and operations side of the facility. A/CNS/LALD-C stated they handwrote their actions to correct the citations on the paperwork received from MDH. A/CNS/LALD-C stated it places residents at risk for harm if the citations are not corrected and was oversight for	0 340			

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0 340	Continued From page 3 not correcting all the citations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{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 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	{0 480}			

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{0 680}	Continued From page 5 (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 maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated June 24, 2025, lacked evidence of the	{0 680}			

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{0 680}	Continued From page 6 following required content: - process for EP collaboration with local, tribal, regional and Federal emergency preparedness systems; - subsistence needs for staff and residents; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for medical documentation; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - names and contact information names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - emergency official contact information including state licensing and certification agency, MN Office of Ombudsman for long-term care; - methods for sharing information; - long-term care (LTC) family notifications; - emergency preparation and testing requirements, and; - emergency Prep Training Program. The licensee's undated documentation of actions taken lacked evidence that steps were taken to correct the deficient practice previously cited following a survey concluded on August 6, 2025. On October 20, 2025, at 1:38 p.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they were aware of the required time frame to correct the citation previous issued. A/CNS/LALD-C stated it was a safety concern if the EP Plan was not compliant. A/CNS/LALD-C stated correcting that order was missed. On October 20, 2025, at 1:38 p.m., and 1:58	{0 680}			

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{0 680}	Continued From page 7 p.m., A/CNS/LALD-C stated they were responsible for correcting the citations related to clinical aspects of the facility and co-owner (C/O)-F was responsible for citations related to the business and operations side of the facility. A/CNS/LALD-C stated it places residents at risk for harm if the citations are not corrected and was oversight for not correcting all the citations. The licensee's 9.01 Emergency Preparedness plan dated October 11, 2021, indicated the licensee would have an emergency preparedness plan that aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. No further information was provided.	{0 680}			
{0 775} SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	{0 775}			

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{0 775}	Continued From page 8 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Controlled egress is only permitted under certain conditions including that they must unlock upon actuation of either an automatic sprinkler system or the automatic smoke detection system. The locking arrangement may prevent occupants from safely and quickly exiting the building during an emergency. This delay may be exacerbated considering the lack of interconnection between smoke alarms throughout the facility which may delay notification of a fire and prompt occupants to exit. A/CNS/LALD-C stated that some residents are aware of the door codes and further inquired about the locking arrangement requirements and acknowledged potential risks with door locking. The egress doors on the facility were equipped with a locking system with a keypad installed on the egress side of the doors which required a passcode to exit the facility. A/CNS/LALD-C stated that the locking system for the egress doors were not connected to the fire alarm system and automatic fire sprinkler system and would not release upon activation of the fire alarm system, automatic fire sprinkler system, or under loss of power as required for controlled egress locking arrangements under Minnesota State Fire Code (MSFC). It was also observed that the egress locking system lacked the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location as required for controlled egress locking under MSFC chapter 1010. A/CNS/LALD-C stated that	{0 775}			

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{0 775}	Continued From page 9 some residents are aware of the door codes and further inquired about the locking arrangement requirements and acknowledged potential risks with door locking. Controlled egress is only permitted under conditions listed in MSFC, including that they must unlock upon actuation of either an automatic sprinkler system or the automatic smoke detection system. A non-compliant locking arrangement poses a serious risk to residents as it may prohibit the ability of any occupants to safely and quickly exit the building during an emergency. This delay may be exacerbated considering the lack of interconnection between smoke alarms throughout the facility which may delay notification of a fire and prompt occupants to exit. Carbon monoxide (CO) detection and alarms were not provided in required locations throughout the facility. A/CNS/LALD-C confirmed that there was not CO detection and alarms present in the building and indicated that required alarms would be provided An older model DSC alarm panel was present observed near the front door of the facility but did not appear functional. A/CNS/LALD-C confirmed to the surveyor that the device was no longer in service and could not provide the date it was last operational or in use in the facility. Any supplied devices that have the appearance of a fire safety device should be maintained or removed to not give a false sense of safety or to otherwise confuse residents, staff, or responding personnel. The facility had an emergency power generator, but no logs of testing on the generator could be located or provided to the surveyor. A/CNS/LALD-C stated that they were not aware of any testing and had no documentation of any	{0 775}			

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{0 775}	Continued From page 10 tests on the generator. Emergency and standby power systems must be tested and maintained to ensure they meet requirements, and records of inspection testing and maintenance should be retained. This tag probably goes under 0680 for nurses and EP plan - unless you have a fire code reference that I am not aware of to include it here under. Resident room 5 had multiplug adapters in use, which were not properly rated for continuous use and may pose risk of fire hazard. Upon entering the building on October 20, 2025 at 10:15 a.m., the surveyor heard a keypad being entered to open the door from the inside. At the end of the tour on October 20, 2025 around 11 a.m., the front door of the facility was locked by the keypad from the egress side and the surveyor could not exit and had to ask staff to unlock the door. Co-owner (CO)-F came to the door to let the surveyor exit and entered the code incorrectly three times which caused the digital keypad lock to disable itself and keep the door locked without anyway to use the lock or get past the front door for some period of time. This presented a serious risk as the lock obstructed egress and prevented exiting the facility. This lock could prevent occupants from getting to safety in an emergency. A/CNS/LALD-C stated that they believed that the locks had been disabled and that they had not seen anyone need a code to exit the building lately. The controlled egress locks on both doors were still present without any fail safe to ensure they unlock with activation of fire alarm, water flow, or remote release. The electronic lock on the rear door was programmed to be unlocked by default and not require a code, but the unapproved	{0 775}			

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{0 775}	Continued From page 11 locking mechanism was still present. No further information was provided by A/CNS/LALD-C or CO-F on generator logs. A/CNS/LALD-C acknowledged the noted deficiencies during the tour and stated that they would correct the deficiencies.	{0 775}			
{0 780} SS=I	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;	{0 780}			

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{0 780}	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 20, 2025 around 11:20 a.m., A/CNS/LALD-C tested smoke alarms by actuating alarms in the upper level hallway and in resident room 3. Upon testing it was found that smoke alarms in the lower level hallway and the upper level bedroom hallway did not sound and were not properly interconnected with all other alarms in the facility. Smoke alarm should be interconnected such that the actuation of any one alarm causes all alarms in to activate and sound to alert others throughout the facility. A/CNS/LALD-C stated they believed all smoke alarms had been interconnected, but acknowledged that the alarms in the lower level hallway and upper level hallway did not properly interconnect. During the facility tour interview on October 20, 2025, A/CNS/LALD-C verified the above listed fire protection and physical environment	{0 780}			

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{0 780}	Continued From page 13	{0 780}			
{0 790} SS=C	observations while accompanying on the tour and expressed that they would ensure interconnection and correct the deficiencies. 144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}			
{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}	Not reviewed during this survey		

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{0 830}	Continued From page 15 This MN Requirement is not met as evidenced by:	{0 830}	Not reviewed during this survey.		
{0 950} SS=B	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced				

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{0 950}	Continued From page 16 by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for two of three residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the assisted living facility on July 5, 2023, and began receiving assisted living services. R3 R3 was admitted to the assisted living facility on June 22, 2021, and began receiving assisted living services. R2, and R3's Assisted Living record lacked evidence the licensee provided the resident any notice with the required verbatim language for designating a representative. The licensee's undated documentation of actions taken to correct the deficient practice previously cited following a survey concluded on August 6, 2025, indicated, "verbatim language used and posted." On October 20, 2025, at 9:31 a.m., agent/clinical	{0 950}			

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{0 950}	Continued From page 17 nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they had requested co-owner (C/O)-F add the required information. On October 20, 2025, at 9:32 a.m., C/O-F stated they did not receive that request from A/CNS/LALD-C. C/O-F stated they were unaware the information was required to be included in the resident file. No further information was provided.	{0 950}			
{01540} SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the 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 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;	{01540}			

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{01540}	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure direct-care staff completed an initial two hours of mental illness and de-escalation training with 80 working hours for two of two employees (agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C, unlicensed personnel ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on February 14, 2025, to provide direct care services. ULP-B's file included a transcript that indicated the following training had been completed: aging process 0.75 hours of training; assisted living bill of rights 0.75 hours of training; assisted living bill of rights 0.75 hours of training; attitude of care 0.50 hours of training; client mobility - exercise and ambulation 0.50 hours of training; client mobility - lifting and safe transfers 0.75 hours of training; client mobility - positioning 0.5 hours of training; client mobility - range of motion 0.75 hours of training; common health problems 1 hour of training;	{01540}			

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{01540}	Continued From page 19 communication 0.5 hours of training; coronavirus COVID-19 0.75 hours of training; cultural competency 1 hour of training; customer service 1 hour of training; dementia - a refresher 1 hour of training; dementia - activities 0.5 hours of training; dementia - activities - a balance approach total 2 units 1.5 hours of training; dementia - activities - bathing 0.75 hours of training; dementia - activities - chores, working, and volunteering 0.75 hours of training; dementia - dementia - dressing and grooming 0.75 hours of training; dementia - dementia - end of life care 0.75 hours of training; dementia - activities - exercise 0.5 hours of training; dementia - activities - hydration, nutrition, eating and dining 0.75 hours of training; dementia - activities - leisure and life enriching activities 0.75 hours of training; dementia - activities - medications, vitals, and treatments 0.5 hours of training; dementia - activities - toileting 0.5 hours of training; dementia - communication - family support 0.5 hours of training; dementia - communication - overview total 2.75 hours of training; dementia - person-center care, 0.75 hours of training; dementia - problem solving - anger and aggression 0.5 hours of training; dementia - problem solving - intimacy and sexuality 0.5 hours of training; dementia - problem solving - paranoia and hallucinations 0.5 hours of training; dementia - problem solving - rummaging and hoarding 0.5 hours of training;	{01540}			

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{01540}	Continued From page 20 dementia - problem solving - sleep problems and sundowning 0.5 hours of training; dementia - problem solving - use of medication 0.75 hours of training; dementia - problem solving - wandering and elopement 0.75 hours of training; dementia - the face of dementia - the journey 1 hour of training; dementia - 1 introduction and overview 1 hour of training; dementia - 2 communication 1.25 hours of training; dementia - activities of daily living 1 hour of training; dementia - 4 behaviors of symptoms 1 hour of training; dementia management and abuse presentation 1.25 hours of training; dining, nutrition, and food safety 1.25 hours of training; documentation, observing, and reporting 0.75 hours of training; emergency preparedness - client issues 0.50 hours of training; emergency preparedness - human hazards 1.5 hours of training; emergency preparedness overview 1.5 hours of training; emergency preparedness site and natural hazards 2 hours of training; fall prevention 0.75 hours of training; first aid 0.75 hours of training; guide to assisted living 1.25 hours of training; HIPAA (health information portability and accountability act) 1 hour of training; hospice and end of life care 0.75 hours of training; housekeeping, laundry and bedmaking 0.75 hours of training; infection control techniques 2 hours of training;	{01540}			

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{01540}	Continued From page 21 infection prevention and control - 0.75 hours of training; medicaid fraud and abuse 0.5 hours of training; medication administration overview 1.25 hours of training; medication administration - routes 1.5 hours of training; medication and treatment - blood glucose and testing 0.5 hours of training; medication and treatment - catheter care - 1.50 hours of training; medication and treatment - compression stockings 0.75 hours of training; medication and treatment - continue positive airway pressure 0.75 hours of training; medication and treatment - insulin administration 0.75 hours of training; medication and treatment - insulin pen 0.5 hours of training; medication and treatment - nebulizer and inhalers 0.5 hours of training; medication and treatment - oxygen saturation 0.75 hours of training; medication and treatment - ostomy care 0.75 hours of training; medication and treatment - 1 hour of training; medication and treatment - wound care 0.75 hours of training; medication reminders 0.75 hours of training; mental illness 0.75 hours of training; occupational safety and health administration (OSHA) - infection control 1.25 hours of training; personal cares - 2.5 hours of training; professional boundaries 0.75 hours of training; slips, trips, and falls 0.5 hours of training; special diets and feeding techniques 0.75 hours of training; vital signs 1 of hour of training, and; vulnerable adult refresher 1.5 hours of training.	{01540}			

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{01540}	Continued From page 22 ULP-B's file lacked the required 1 hour of de-escalation training. A/CNS/LALD-C A/CNS/LALD-C was hired on April 22, 2022, to provide supervisory and direct care services. A/CNS/LALD-C's file included a transcript that indicated the following training had been completed: assisted living bill of rights 1.50 hours of training; conflict resolution 0.75 hours of training; dementia activities - balanced approach 1.50 hours of training; dementia activities - communication overview 2 hours of training; dementia activities - person centered care - 0.75 hours of training; dementia activities - problem solving anger and aggression 0.50 hours of training; dementia activities problem solving - overview 1.50 hours of training; dementia problem solving - sleep problems and sundowning 0.50 hours of training; dementia 1 - introduction and overview 1 hour of training; dementia 2 - communication 1.25 hours of training; dementia 3 activities of daily living 1 hour of training; dementia 4 behaviors vs symptoms 1 hour of training; dementia 5 the journey 0.75 hours of training; emergency preparedness - human hazards 1.50 hours of training; emergency preparedness - overview 1.50 hours of training; emergency preparedness site and natural hazards 2 hours of training; guide to assisted living - 1 hour of training;	{01540}			

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{01540}	Continued From page 23 HIPAA 1 hour of training; infection control techniques 2 hours of training; medicaid fraud and abuse 0.50 hours of training; OSHA and infection control 1.25 hours of training; person-center care principles 1 hour of training, and; vulnerable adult 2 hours of training. A/CNS/LALD-C's file lacked the required mental illness and de-escalation training. On October 20, 2025, at 1:38 p.m., A/CNS/LALD-C stated they assigned Educare (online training program) classes to staff that included conflict resolution and communication and believed that met the training requirements. A/CNS/LALD-C stated that was the recommendation from the Educare training company was to use those trainings. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated all direct care employees would complete eight (8) hours of initial training within 80 hours of the employment start date. The policy lacked content that addressed the requirement of mental illness and de-escalation training. No further information was provided.	{01540}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the	{02040}			

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{02040}	Continued From page 24 assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}	Not reviewed during this survey		
{02060} SS=I	144G.81 Subd. 3 Assisted living facilities with dementia care (a) All assisted living facilities with dementia care and a secured dementia care unit must meet the applicable provisions of the 2018 edition of the NFPA Standard 101, Life Safety Code, Healthcare (limited care) chapter. The minimum design standards shall be met for all new licenses or new construction. (b) If the commissioner decides to update the Life Safety Code for purposes of this subdivision, the commissioner must notify the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health care and public safety of the planned update by January 15 of the year in which the new Life Safety Code will become effective. Following notice from the commissioner, the new edition shall become effective for assisted living facilities with dementia care and a secured dementia care unit beginning August 1 of that year, unless provided otherwise in law. The commissioner shall, by publication in the State Register, specify a date by which these facilities must comply with the updated Life Safety Code. The date by which	{02060}			

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{02060}	Continued From page 25 these facilities must comply shall not be sooner than six months after publication of the commissioner's notice in the State Register. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with National Fire Protection Association (NFPA) 101 Life Safety Code, Healthcare (Limited Care) Occupancies chapter. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 5, 2025, from approximately 1:40 p.m. to 3:00 p.m., with agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C, the surveyor observed that an automatic fire sprinkler system had been installed in the facility that was not noted on previous surveys. A record review indicated that this modification did not receive a review and approval from the Minnesota Department of Health (MDH) under Minnesota Statute 144G.45 and 144G.81. An automatic fire sprinkler system installed in an assisted living facilities with dementia care licensure must comply with section 18.3.5.4 and section 9.7.1.1(1) of the 2018 NFPA 101, Life	{02060}			

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{02060}	Continued From page 26 Safety Code and must be in compliance with NFPA 13, Standard for the Installation of Sprinkler Systems and not the residential standards of NFPA 13D. During a facility tour on October 20, 2025, the surveyor inquired for information from A/CNS/LALD-C and co-owner (CO)-F regarding information on the sprinkler system and documentation that it had been submitted to MDH for approval. A/CNS/LALD-C stated that no documents had been submitted to MDH and indicated they did not believe it was required. The surveyor explained requirements for sprinkler systems and the approval process for a state licensed facility.	{02060}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 22, 2025

Licensee

Happy Home LLC
6660 West 175th Avenue
Eden Prairie, MN 55346

RE: Project Number(s) SL25323016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

- St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$3,000.00**
- St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$1,000.00**
- St - 0 - 2060 - 144g.81 Subd. 3 - Assisted Living Facilities With Dementia Care - \$1,000.00**
- St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25323	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2025
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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: SL25232016-0 On August 4, 2025, through August 6, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were six residents; six receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on August 4, 2025, issued for SL25232016-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (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 develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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: On August 4, 2025, at 9:56 a.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated one unlicensed personnel (ULP) worked each shift and the shift schedule was 7:30 a.m. until 2:00 p.m., 1:30 p.m. until 8:00 p.m., and 8:00 p.m. until 8:00 a.m., and A/CNS/LALD-C worked Monday through Friday 7:30 a.m. until 5:00 p.m. On August 5, 2025, at 11:19 a.m., A/CNS/LALD-C provided a documented titled [licensee] Direct Care Staffing Plan. The document lacked evidence a registered nurse (RN) had evaluated the staffing plan and lacked a date. On August 5, 2025, at 11:10 a.m., A/CNS/LALD-C stated they were responsible for ensuring there was coverage for each shift at the facility. A/CNS/LALD-C stated they were unaware the staffing plan had to be evaluated twice a year by a registered nurse. The licensee's undated, 4.06 Staffing & Schedule policy indicated the clinical nurse supervisor would develop and implement a staffing plan that provides an adequate number of qualified staff to meet the residents needs 24-hours a day, seven days a week. The policy lacked guidance the CNS was required to evaluate the staffing plan at	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 least every six months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	0 480			

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0 480	Continued From page 4 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 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 480			

Minnesota Department of Health

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0 480	Continued From page 5 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (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.	0 650			

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0 650	Continued From page 6 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure proper documentation was completed for demonstration of competency for two of three staff (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on September 17, 2024, to provide direct care services. ULP-A's employee record lacked evidence of the following demonstration of competency: - standby assistance techniques and how to perform them. On August 5, 2025, at 2:36 p.m., ULP-A stated they could remember the clinical nurse supervisor (CNS) demonstrated skills including obtaining a blood pressure, safe transfer, and stand by assist, and they were required to perform a return demonstration back to the CNS. ULP-B ULP-B was hired on February 14, 2025, to	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 provide direct care services. ULP-B's employee record lacked evidence of the following demonstration of competency: - standby assistance techniques and how to perform them. On August 5, 2025, at 12:43 p.m., ULP-B stated they could remember the CNS demonstrated skills including how to use a gait belt (a belt that is placed around a person to assist to a standing position), how to use a walker with the resident, and how to transfer a resident from the wheelchair to a normal chair. On August 5, 2025, at 1:02 p.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they were responsible for the training of staff. A/CNS/LALD-C stated the documentation was not completed. The licensee's 5.02 Competency Training Evaluations policy indicated training and competency testing shall be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660			

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0 660	Continued From page 8 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 interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening within 90 days of hire for one of three employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on September 17, 2024, to provide direct care services. ULP-A's employee record lacked a TB history and symptom screening tool completed upon hire.	0 660			

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0 660	Continued From page 9 On August 4, 2025, at 12:09 p.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated the TB screening should had been completed upon hire and they were responsible for completing the TB screenings. A/CNS/LALD-C stated it was just missed and was a nursing error. The licensee's TB Prevention and Control policy dated May 19, 2022, indicated licensee would follow the most current guidelines issued by the Center for Disease Control. The Minnesota Department of Health Tuberculosis Prevention and Control Program dated July 2013 recommended a TB screening was required for all healthcare workers, which consisted of assessment for current symptoms of active TB disease, assessing TB history, testing for the presence of infection <i>Mycobacterium tuberculosis</i> by administered either a two-step tuberculosis skin test (TST), or single interferon gamma release assay (a blood test to determine if a person has been infected with TB). The CDC Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated May 17, 2019, recommended all United States health care personnel should have a completed a TB risk assessment, symptom evaluation, TB testing for tuberculosis, with additional working for TB disease with a positive test results or symptoms compatible with TB disease. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

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0 680	Continued From page 10	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

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NAME OF PROVIDER OR SUPPLIER HAPPY HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6660 WEST 175TH AVENUE EDEN PRAIRIE, MN 55346		
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0 680	Continued From page 11 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated June 24, 2025, lacked evidence of the following required content: - process for EP collaboration with local, tribal, regional and Federal emergency preparedness systems; - subsistence needs for staff and residents; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for medical documentation; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - names and contact information names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; -emergency official contact information including state licensing and certification agency, MN Office of Ombudsman for long-term care; - methods for sharing information; - long-term care (LTC) family notifications; - emergency preparation and testing requirements, and; - emergency Prep Training Program. On August 5, 2025, at 3:17 p.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they were hired into that	0 680			

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0 680	Continued From page 12 role in July 2024. A/CNS/LALD-C stated they believed the EP plan was compliant. A/CNS/LALD-C stated that was the EP Plan used by the previous owners of the assisted living facility. The licensee's 9.01 Emergency Preparedness plan dated October 11, 2021, indicated the licensee would have an emergency preparedness plan that aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 775			

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0 775	Continued From page 13 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2025, from approximately 1:40 p.m. to 3:00 p.m., the surveyor toured the facility with agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C and the surveyor observed the following: Controlled egress is only permitted under certain conditions including that they must unlock upon actuation of either an automatic sprinkler system or the automatic smoke detection system. The locking arrangement may prevent occupants from safely and quickly exiting the building during an emergency. This delay may be exacerbated considering the lack of interconnection between smoke alarms throughout the facility which may delay notification of a fire and prompt occupants to exit. A/CNS/LALD-C stated that some residents are aware of the door codes and further inquired about the locking arrangement requirements and acknowledged potential risks with door locking. The egress doors on the facility were equipped with a locking system with a keypad installed on the egress side of the doors which required a passcode to exit the facility. A/CNS/LALD-C stated that the locking system for the egress doors were not connected to the fire alarm system and automatic fire sprinkler system and would not release upon activation of the fire alarm system, automatic fire sprinkler system, or under loss of power as required for controlled egress locking arrangements under Minnesota State Fire Code (MSFC).	0 775			

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0 775	Continued From page 14 It was also observed that the egress locking system lacked the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location as required for controlled egress locking under MSFC. A/CNS/LALD-C stated that some residents are aware of the door codes and further inquired about the locking arrangement requirements and acknowledged potential risks with door locking. Controlled egress is only permitted under conditions listed in MSFC, including that they must unlock upon actuation of either an automatic sprinkler system or the automatic smoke detection system. A non-compliant locking arrangement poses a serious risk to residents as it may prohibit the ability of any occupants to safely and quickly exit the building during an emergency. This delay may be exacerbated considering the lack of interconnection between smoke alarms throughout the facility which may delay notification of a fire and prompt occupants to exit. Carbon monoxide (CO) detection and alarms were not provided in required locations throughout the facility. A/CNS/LALD-C confirmed that there was not CO detection and alarms present in the building and indicated that required alarms would be provided An older model DSC alarm panel was present observed near the front door of the facility but did not appear functional. A/CNS/LALD-C confirmed to the surveyor that the device was no longer in service and could not provide the date it was last operational or in use in the facility. Any supplied devices that have the appearance of a fire safety device should be maintained or removed to not give a false sense of safety or to otherwise confuse residents, staff, or responding personnel.	0 775			

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0 775	Continued From page 15 The facility had an emergency power generator, but no logs of testing on the generator could be located or provided to the surveyor. A/CNS/LALD-C stated that they were not aware of any testing and had no documentation of any tests on the generator. Emergency and standby power systems must be tested and maintained to ensure they meet requirements, and records of inspection testing and maintenance should be retained. This tag probably goes under 0680 for nurses and EP plan - unless you have a fire code reference that I am not aware of to include it here under. Resident room 5 had multiplug adapters in use, which were not properly rated for continuous use and may pose risk of fire hazard. A/CNS/LALD-C acknowledged the noted deficiencies during the tour and stated that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 780 SS=I	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;	0 780			

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0 780	Continued From page 16 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2025, from approximately 1:40 p.m. to 3:00 p.m., the surveyor toured the facility with agent/clinical nurse supervisor/licensed assisted	0 780			

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0 780	Continued From page 17 living director (A/CNS/LALD)-C and the surveyor observed the following: During the tour A/CNS/LALD-C tested smoke alarms by activating alarms in the upper-level bedroom hallway, and lower-level common room. No smoke alarms were interconnected, and the activation of any particular smoke alarm did not trigger any other alarms to sound. During the testing of the smoke alarms it was noted that some basement alarms could not be clearly heard from main level of the facility. Smoke alarm should be interconnected such that the actuation of any one alarm causes all alarms in to activate and sound to alert others throughout the facility. A/CNS/LALD-C indicated they were unaware of interconnection requirements but expressed that they would correct the deficiencies. During the facility tour interview on August 5, 2025, A/CNS/LALD-C verified the above listed fire protection and physical environment observations while accompanying on the tour. and expressed that they would ensure interconnection and correct the deficiencies. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	0 790			

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0 790	Continued From page 18 fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 5, 2025, from approximately 1:40 p.m. to 3:00 p.m., the surveyor toured the facility with agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C. During the tour, the surveyor observed the following deficient conditions: The fire extinguishers provided throughout the facility, in the kitchen and basement common area did not have records of monthly inspections by facility staff. The extinguishers had current annual service tags by Summit dated February 2025, but no records for monthly inspections were present. During the tour and interview, A/CNS/LALD-C	0 790			

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0 790	Continued From page 19 indicated they were unaware of monthly inspection requirements and would begin conducting and recording such inspections. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (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	0 810			

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0 810	Continued From page 20 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 5, 2025, at approximately 2:30 p.m., agent/licensed assisted living director/clinical nurse supervisor (A/CNS/LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to include the location and number of resident rooms. Facility maps and documents did not number or otherwise identify resident rooms, and no such designators were located on or near the resident room doors making it difficult to identify specific rooms.	0 810			

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0 810	Continued From page 21 The provided FSEP documents appeared outdated and did not include information about generator for backup power, sprinkler system, or door locks. The evacuation maps had the garage marked as an exit which is not permitted by fire code. The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. A/CNS/LALD-C expressed that training is done verbally with residents, but there is no recorded plan or procedures. The FSEP failed to identify unique resident needs for evacuation or movement during fire or similar emergency. Patient charts included notes on ambulation requirements during day-to-day operations, but no specific information related to resident evacuation and safety was provided. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. Staff was unable to provide documentation showing adequate trainings were provided for employee training on the fire safety and evacuation plan. A/CNS/LALD-C stated that employees are trained once annually and provided documentation of that training. Employees should be provided training upon hire and at least twice a year thereafter and trainings should be specific to the facility and FSEP plans. Record review indicated that the licensee failed to provide and document adequate evacuation drills. Evacuation drill records were provided from Rtask, however the most recent evacuation drill	0 810			

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0 810	Continued From page 22 was on March 13, 2025, at 12:45 pm. A/CNS/LALD-C confirmed that no more recent drills had been provided and indicated that staff had been so busy that continuing regular fire safety drills was overlooked in the last few months. Evacuation drills are required for employees at least twice per year per shift and at least once every other month. A/CNS/LALD-C indicated that regular evacuation drills would resume. During an interview on August 5, 2025, at approximately 2:50 p.m., the surveyor explained the requirements for employee trainings, evacuation drills and FSEP documentation. A/CNS/LALD-C stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain the required	0 830			

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0 830	Continued From page 23 approvals prior to construction or modification in accordance with Minnesota Statute 144G. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On a facility tour on August 5, 2025, from approximately 1:40 p.m. to 3:00 p.m., with agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C, the surveyor observed that an automatic fire sprinkler system had been installed in the facility that was not noted on previous surveys. A record review indicated that this modification did not receive a review and approval from the Minnesota Department of Health (MDH) under Minnesota Statute 144G.45 and 144G.81. During interview, A/CNS/LALD-C stated that the automatic fire sprinkler system had been installed in August of 2024 and that they obtained the required local permits but could not provide verification of review and approval from MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			

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0 950	Continued From page 24	0 950			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for three of	0 950			

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NAME OF PROVIDER OR SUPPLIER HAPPY HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6660 WEST 175TH AVENUE EDEN PRAIRIE, MN 55346		
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0 950	Continued From page 25 three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the assisted February 6, 2020, and began receiving assisted living services. R2 was admitted to the assisted living facility on July 5, 2023, and began receiving assisted living services. R3 was admitted to the assisted living facility on June 22, 2021, and began receiving assisted living services. R1, R2, and R3's Assisted Living record lacked evidence the licensee provided the resident any notice with the required verbatim language for designating a representative. On August 5, 2025, at 11:22 a.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they were unaware of the required language for designating a representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			

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01370	Continued From page 26	01370			
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370			

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01370	Continued From page 27 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on September 17, 2024, to provide direct care services. ULP-A's employee record lacked evidence for the following training: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal	01370			

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01370	Continued From page 28 hygiene and grooming, including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids and dressing and assisting with toileting; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the -resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On August 5, 2025, at 2:36 p.m. ULP-A stated they recalled completing some online trainings but did not remember the subjects of the trainings. ULP-A stated they had issues using Educare (an online training program) and was aware they still had training to complete. ULP-B ULP-B was hired on February 14, 2025, to provide direct care services. ULP-B's employee record lacked evidence of the following training: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider, and;	01370			

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01370	Continued From page 29 - awareness of commonly used health technology equipment and assistive devices. On August 5, 2025, at 1:02 p.m., the surveyor observed agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C looking at ULP-A's Educare transcript on a laptop computer. ULP-A was assigned but had not completed the following trainings: abuse prevention, assisted living bill of rights, dementia - communication, emergency preparedness - human hazards and Minnesota assisted living, falls prevention, infection control techniques, person-centered care principles, and vulnerable adults. A/CNS/LALD-C stated the trainings were not completed by ULP-A. The licensee's 5.02 Competency Training Evaluation policy dated December 1, 2023, indicated staff would be trained in the areas as stated above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;	01380			

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01380	Continued From page 30 (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on September 17, 2024, to provide direct care services. ULP-A's employee record lacked evidence for the following training: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and	01380			

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01380	Continued From page 31 changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation, and; -range of motioning and positioning. On August 5, 2025, at 2:36 p.m. ULP-A stated they recalled completing some online trainings but did not remember the subjects of the trainings. ULP-A stated they had issues using Educare (an online training program) and was aware they still had training to complete. ULP-B ULP-B was hired on February 14, 2025, to provide direct care services. ULP-B's employee record lacked evidence of the following training: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. On August 5, 2025, at 1:02 p.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they were responsible for the training of staff. A/CNS/LALD-C stated they were unable to recall of all the training requirements for staff. The licensee's 5.02 Competency Training Evaluation policy dated December 1, 2023, indicated staff would be trained in the areas as stated above. No further information was provided.	01380			

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01380	Continued From page 32	01380			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83.	01460			

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01460	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required orientation training content for one of three employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on September 17, 2024, to provide direct care services. ULP-A's employee record lacked orientation training for the following areas: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license, and;	01460			

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01460	Continued From page 34 - principles of person-centered planning/service delivery. On August 5, 2025, at 1:02 p.m., the surveyor observed agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C looking at ULP-A's Educare (an online training program) transcript on a laptop computer. ULP-A was assigned but had not completed the following trainings: abuse prevention, assisted living bill of rights, dementia - communication, emergency preparedness - human hazards and Minnesota assisted living, falls prevention, infection control techniques, person-centered care principles, and vulnerable adults. A/CNS/LALD-C stated the trainings were not completed by ULP-A. On August 5, 2025, at 2:36 p.m. ULP-A stated they recalled completing some online trainings but did not remember the subjects of the trainings. ULP-A stated they had issues using Educare and was aware they still had training to complete. The licensee's 5.01 Orientation of Staff and Supervisors policy dated December 1, 2023, indicated staff would receive training in the above stated areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least	01540			

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01540	Continued From page 35 eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the 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 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 interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for two of three employees (unlicensed personnel (ULP)-A, ULP-B). Additionally, the licensee failed to ensure direct-care staff completed an initial two hours of mental illness and de-escalation training with 80 working hours for three of three employees (agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD-C, ULP-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01540			

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01540	Continued From page 36 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on September 17, 2024, to provide direct care services. The licensee's Staff Schedule for June and July 2025 indicated ULP-A was scheduled to work 262 hours. ULP-B ULP-B was hired on February 14, 2025, to provide direct care services. The licensee's Staff Schedule for June and July 2025 indicated ULP-B was scheduled to work 270 hours. ULP-A and ULP-B's employee records lacked at least eight hours of initial dementia care training within 80 working hours of employee's start date. A/CNS/LALD-C A/CNS/LALD-C was hired on April 22, 2022, to provide supervisory and direct care services. On August 4, 2025, at 9:56 a.m., A/CNS/LALD-C stated they worked full time for the licensee, and their hours were 7:00 a.m. until 5:00 p.m., Monday through Friday. A/CNS/LALD-C, ULP-A, and ULP-B's employee records lacked two hours of mental illness and de-escalation training.	01540			

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01540	Continued From page 37 On August 6, 2025, 10:00 a.m., A/CNS/LALD-C stated they were unaware of the dementia care and mental illness and de-escalation training requirement. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated all direct care employees would complete eight (8) hours of initial training within 80 hours of the employment start date. The policy lacked content that addressed the requirement of mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01770			

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01770	Continued From page 38 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 the assisted living facility February 6, 2020, and began receiving assisted living services. R1's Signed Service Plan (Waiver) - Addendum to Contract dated August 2, 2023, indicated R1 received assistance with medication administration. R1's Medication Administration Record (MAR) dated July 1, 2025, through July 31, 2025, indicated R1 received the following medications: Advair Diskus 500 -50 micrograms (mcg) 1 puff once daily, cetirizine 10 milligram (mg) 1 tablet once daily, lactobacillus probiotic 1 capsule once daily, levothyroxine 75 mcg 1 table once daily, loperamide 2 mg 1 capsule once daily, multivitamin 1 tablet once daily, venlafaxine 50 mg 1 tablet once daily, Cortef 5 mg tablet three times daily, lactase enzyme oral 3000 units (u) 3 tablets three times daily, Genotropin 0.8 mg injection once daily, desmopressin acetate one-half tablet once daily, and trazadone 25 mg one-half tablet once daily. R2 R2 was admitted to the assisted living facility on July 5, 2023, and began receiving assisted living services.	01770			

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01770	Continued From page 39 R2's Service Plan (Private) - addendum to Contract indicated R2 received assistance with medication administration. R2's MAR dated July 1, 2025, through July 31, 2025, indicated R2 received the following medications: allopurinol 100 mg 2 tablets once daily, aspirin enteric coated (EC) 81 mg tablet once daily, atenolol 25 mg tablet twice daily, dorzolamide-timolol apply 1 drop to each eye twice daily, levothyroxine 112 mcg once daily, saccharomyces boulardii probiotic 250 mg 1 capsule once daily, sertraline one-half tablet 25 mg once daily, torsemide 10 mg 1 tablet once daily, loratadine 10 mg 1 tablet once daily, Occuvite 1 tablet once daily, latanoprost 1 drop to each eye once daily, and simvastatin 40 mg 1 tablet once daily R3 R3 was admitted to the assisted living facility on June 22, 2021, and began receiving assisted living services. R3's Service Plan (waiver) - Addendum to Contract dated August 1, 2025, indicated R3 received assistance with medication administration. R3's MAR dated July 1, 2025, through July 31, 2025, indicated R3 received the following medications: amiodarone 200 mg 1 tablet once daily, gabapentin 100 mg 1 capsule once daily, lactase 1 tablet three times daily, Lasix 40 mg 1 tablet once daily, levetiracetam 500 mg 1 tablet twice daily, levothyroxine 75 mcg 1 tablet once daily, metoprolol 25 mg 1 tablet once daily, omeprazole 20 mg 1 capsule once daily, potassium 20 milliequivalent (meq) 1 tablet once daily, rosuvastatin 20 mg one-half tablet once	01770			

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01770	Continued From page 40 daily, sertraline 100 mg 1 tablet once daily, Vanicream apply to hands once daily, vitamin D3 2000 u 1 capsule once daily, Xarelto 15 mg 1 tablet once daily, lisinopril 2.5 mg 1 tablet once daily, melatonin 3 mg 1 tablet once daily, and mirtazapine 30 mg 1 tablet once daily. On August 4, 2025, at 11:06 a.m., during a facility tour, the surveyor observed a cabinet that contained medication pill boxes for residents. Agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they set up the medications for each resident monthly. R1, R2, and R3' records lacked medication setup documentation. On August 5, 2024, at 9:37 a.m., A/CNS/LALD-C stated they were responsible for setting up the medications for residents. A/CNS/LALD-C stated they had not been documenting the medication setup and was unaware of the requirement. The licensee's 7.08 Medication Management - Administration and Setup policy dated December 1, 2023, indicated the registered nurse (RN) would document the medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is	01820			

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01820	Continued From page 41 managing for the resident. This MN Requirement is not met as evidenced by: Based on interview, and record review, licensee failed to maintain current signed prescription orders for all medications the licensee was managing for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the assisted February 6, 2020, and began receiving assisted living services. R1's Signed Service Plan (Waiver) - Addendum to Contract dated August 2, 2023, indicated R1 received assistance with medication administration. R1's Medication Administration Record (MAR) dated July 1, 2025, through July 31, 2025 indicated R1 received the following medications: Advair Diskus 500 -50 micrograms (mcg) 1 puff once daily, cetirizine 10 milligram (mg) 1 tablet once daily, lactobacillus probiotic 1 capsule once daily, levothyroxine 75 mcg 1 table once daily, loperamide 2 mg 1 capsule once daily,	01820			

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01820	Continued From page 42 multivitamin 1 tablet once daily, venlafaxine 50 mg 1 tablet once daily, Cortef 5 mg tablet three times daily, lactase enzyme oral 3000 units (u) 3 tablets three times daily, Genotropin 0.8 mg injection once daily, desmopressin acetate one-half tablet once daily, and trazadone 25 mg one-half tablet once daily. R2 R2 was admitted to the assisted living facility on July 5, 2023, and began receiving assisted living services. R2's Service Plan (Private) - addendum to Contract indicated R2 received assistance with medication administration. R2's MAR dated July 1, 2025, through July 31, 2025, indicated R2 received the following medications: allopurinol 100 mg 2 tablets once daily, aspirin enteric coated (EC) 81 mg tablet once daily, atenolol 25 mg tablet twice daily, dorzolamide-timolol apply 1 drop to each eye twice daily, levothyroxine 112 mcg once daily, saccharomyces boulardii probiotic 250 mg 1 capsule once daily, sertraline one-half tablet 25 mg once daily, torsemide 10 mg 1 tablet once daily, loratadine 10 mg 1 tablet once daily, Occuvite 1 tablet once daily, latanoprost 1 drop to each eye once daily, and simvastatin 40 mg 1 tablet once daily. R3 R3 was admitted to the assisted living facility on June 22, 2021, and began receiving assisted living services. R3's Service Plan (waiver) - Addendum to Contract dated August 1, 2025, indicated R3 received assistance with medication	01820			

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01820	Continued From page 43 administration. R3's MAR dated July 1, 2025, through July 31, 2025, indicated R3 received the following medications: amiodarone 200 mg 1 tablet once daily, gabapentin 100 mg 1 capsule once daily, lactase 1 tablet three times daily, Lasix 40 mg 1 tablet once daily, levetiracetam 500 mg 1 tablet twice daily, levothyroxine 75 mcg 1 tablet once daily, metoprolol 25 mg 1 tablet once daily, omeprazole 20 mg 1 capsule once daily, potassium 20 milliequivalent (meq) 1 tablet once daily, rosuvastatin 20 mg one-half tablet once daily, sertraline 100 mg 1 tablet once daily, Vanicream apply to hands once daily, vitamin D3 2000 u 1 capsule once daily, Xarelto 15 mg 1 tablet once daily, lisinopril 2.5 mg 1 tablet once daily, melatonin 3 mg 1 tablet once daily, and mirtazapine 30 mg 1 tablet once daily R1, R2, and R3's records lacked signed prescriber orders. On August 5, 2025, at 9:37 a.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated if a medication was prescribed, they would obtain a signed order from the medical provider or a copy of the prescription from the pharmacy. The surveyor observed A/CNS/LALD-C using the online electronic medical record (EMAR) to search for the signed orders but was not able to provide the documents. A/CNS/LALD-C stated the licensee was transitioning from paper copies to the EMAR. A/CNS/LALD-C believed the list of medication had been signed by the providers and was located in the EMAR. No further information was provided.	01820			

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01820	Continued From page 44	01820			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide an appropriate hazard vulnerability assessment and required documentation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	02040			

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02040	Continued From page 45 The findings include: On August 5, 2025, at approximately 2:30 p.m., agent/licensed assisted living director/clinical nurse supervisor (A/CNS/LALD)-C provided documents on the fire protection and physical environment of the property. The licensee provided a hazard vulnerability assessment that was only partially completed with many of the potential hazards not scored or addressed. The hazards that were identified did not include proper mitigation or any documentation of how they were addressed by the facility. When questioned A/CNS/LALD-C indicated that the biggest concerns for the facility were elopement and fall risk, which were not included on the hazard vulnerability assessment. Documents appeared dated and did not include information on sprinkler systems or generator. No mitigation was listed in the provided documents. The facility should adequately assess and mitigate safety risks to protect residents from harm. During the record review and interview on August 5, 2025, A/CNS/LALD-C verified the hazard vulnerability assessment was not sufficiently complete. A/CNS/LALD-C stated that they understood requirements and would perform a hazard vulnerability assessment and identify mitigation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02060 SS=I	144G.81 Subd. 3 Assisted living facilities with dementia care (a) All assisted living facilities with dementia care and a secured dementia care unit must meet the	02060			

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02060	Continued From page 46 applicable provisions of the 2018 edition of the NFPA Standard 101, Life Safety Code, Healthcare (limited care) chapter. The minimum design standards shall be met for all new licenses or new construction. (b) If the commissioner decides to update the Life Safety Code for purposes of this subdivision, the commissioner must notify the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health care and public safety of the planned update by January 15 of the year in which the new Life Safety Code will become effective. Following notice from the commissioner, the new edition shall become effective for assisted living facilities with dementia care and a secured dementia care unit beginning August 1 of that year, unless provided otherwise in law. The commissioner shall, by publication in the State Register, specify a date by which these facilities must comply with the updated Life Safety Code. The date by which these facilities must comply shall not be sooner than six months after publication of the commissioner's notice in the State Register. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with National Fire Protection Association (NFPA) 101 Life Safety Code, Healthcare (Limited Care) Occupancies chapter. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	02060			

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02060	Continued From page 47 has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 5, 2025, from approximately 1:40 p.m. to 3:00 p.m., with agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C, the surveyor observed that an automatic fire sprinkler system had been installed in the facility that was not noted on previous surveys. A record review indicated that this modification did not receive a review and approval from the Minnesota Department of Health (MDH) under Minnesota Statute 144G.45 and 144G.81. During interview, A/CNS/LALD-C stated that the automatic fire sprinkler system had been installed in August of 2024 and that they obtained the required local permits from the City of Eden Prairie. On August 14, 2025, between 4:10 p.m. and 5:00 p.m., the surveyor contacted the City of Eden Prairie and inquired about the permitting and approval of the installed fire sprinkler system. Eden Prairie city staff confirmed that a permit was obtained for an automatic fire sprinkler system in compliance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes to be installed in the facility. On August 24, 2025, the surveyor received permit documents from the City of Eden Prairie for the installation of the automatic fire sprinkler system. Record review of the submitted documents confirmed that the automatic fire sprinkler system was installed in accordance with NFPA 13D,	02060			

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02060	Continued From page 48 Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes to be installed in the facility. An automatic fire sprinkler system installed in an assisted living facilities with dementia care licensure must comply with section 18.3.5.4 and section 9.7.1.1(1) of the 2018 NFPA 101, Life Safety Code and must be in compliance with NFPA 13, Standard for the Installation of Sprinkler Systems and not the residential standards of NFPA 13D. TIME PERIOD FOR CORRECTION: Two (2) days	02060			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents with bed rails (R1, R2). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems	02310			

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02310	Continued From page 49 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). HOSPITAL BED RAIL R1 R1 was admitted to the assisted living facility February 6, 2020, and began receiving assisted living services. R1's diagnoses included brain tumor, asthma (a breathing condition where the lung cells constrict causing breathing difficulties), blind - right eye, depression, diabetes insipidus (body's inability to properly regular fluid levels, leading to excessive urination and intense first), difficulty regulating emotions, incontinent of urine, lactose intolerance, memory loss, and vision impaired - left eye. R1's Signed Service Plan (Waiver) - Addendum to Contract dated August 2, 2023, indicated R1 received assistance with ambulation/transfers, bathing, linen exchange, dressing, exercising, housekeeping, laundry, medication administration, monitor fluid intake, monitor rash, positioning, socializing, toileting, and vital sign record. On August 4, 2025, at 11:09 a.m., during a facility tour, the surveyor observed R1's hospital style bed with bilateral (two) bed rails. The bed rails had an identifying label that read, "MDS89697." There were three main sections to both bed rails. Starting from the left side of the rail, there were two areas that measured three- and one-half inches (") each with a height of 12". The next area had five sections that measured two- and one- half inches each in length with a height of	02310			

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02310	Continued From page 50 18". The next area had two sections that measured three- and one-half inches in length with a height of 12". Both bed rails were firmly attached to the hospital bed. R1's Bed Safety Assessment dated July 23, 2025, lacked the following required information: - measurements of the individual zones; - the residents bed rail use/need assessment; - the residents preferences; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements and; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation. On August 4, 2025, at 12:25 p.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C provided the surveyor with a document titled A Guide to Bed Safety, however, the document was an information pamphlet and was not reflective of or individualized for R1's bed rails. R1's record lacked evidence alternatives or interventions were considered or discussed with R1. A/CNS/LALD-C provided another document titled Safety Checklist and Instructions for R1. The document was signed by the licensee. The document lacked instructions or guidelines for proper installation. On August 4, 2025, at 12:27 p.m., A/CNS/LALD-C stated they were responsible for the bed rail assessment for R1. The surveyor observed A/CNS/LALD-C looking at the Bed Safety Assessment dated July 23, 2025; A/CNS/LALD-C was not able to show the surveyor where the above information was located. A/CNS/LALD-C stated they measured the zones; they did not document the resident	02310			

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02310	Continued From page 51 preferences and had only had a conversation with R1's power of attorney (POA). A/CNS/LALD-C stated they followed the Bed Safety Assessment template in Residex (an online electronic medical administration record). A/CNS/LALD-C stated they were unaware of the required content for hospital bed rails. CONSUMER BED RAIL R2 R2 was admitted to the assisted living facility on July 5, 2023, and began receiving assisted living services. R2s diagnoses included anemia (condition where the body doesn't produce enough healthy red blood cells), aortic valve replacement (heart valve), atrial fibrillation (irregular heart beat), cardiac pacemaker (an implant medical device that regulars heart rhythm), chronic diarrhea, chronic kidney disease, coronary artery disease (disease that damages arteries in the heart), hypertension (high blood pressure), fatigue (tiredness), heart failure, hypercholesteremia (high cholesterol), hypothyroidism (unactive thyroid gland that is responsible for metabolic processes). and peripheral vascular disease (disease process that damages veins and arteries in the arms and legs). On August 4, 2025, at 11:15 a.m., during a facility tour, the surveyor observed bilateral Halo consumer bed rails. There were no identifying marks on either bed rail. Both bed rails measured 12 inches (") in diameter with a top and bottom section. The top section had three individual slots. The bottom section had four individual slots. There were attached to the metal rod that was underneath the bed and secured with a	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25323	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER HAPPY HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6660 WEST 175TH AVENUE EDEN PRAIRIE, MN 55346		
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02310	Continued From page 52 bracket on the metal rod. Both bed rails were firmly secured and there were no large gaps between the bed and the bed rail. R2's Bed Safety Assessment dated July 23, 2025, lacked the following required information: - purpose and intention of the bed rail; - condition and description; - the resident's bed rail use/need assessment; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - risk vs. benefits discussion and; - recall search related to the Halo bed rail. On August 4, 2025, at 12:25 p.m., A/CNS/LALD-C provided the surveyor with a document titled A Guide to Bed Safety, however the document was an information pamphlet and was not reflective or individualized for R2's bedrails. R2's record lacked evidence of alternatives or interventions were considered or discussed with R2. On August 4, 2025, at 12:39 p.m., A/CNS/LALD-C stated R2 moved to the assisted living facility with the bed and bed rails. A/CNS/LALD-C was advised from R2's medical provider to have a physical therapy company perform an assessment on the bed rail. A/CNS/LALD-C stated the physical therapy company came to the facility and told A/CNS/LALD-C the bed rail "looked good." A/CNS/LALD-C stated they were not provided any documentation from the physical therapy company from the onsite visit. A/CNS/LALD-C stated they used the template in Residex to perform the bed rail assessment. A/CNS/LALD-C stated they were not aware of the required information for the bed rail assessment and was	02310			

Minnesota Department of Health

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02310	Continued From page 53 not able to show the surveyor the missed required information. The licensees 6.28 Side Rail policy dated December 1, 2023, indicated licensee would assess for use, educate the resident, and when appropriate the responsible person, regarding the risks of side rails and verify that the side rail in use of a safety design and utilized with the manufacturer's directions. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, Documentation about a resident's hospital-style bed rails includes, but is not limited to: - purpose and intention of the bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.	02310			

Minnesota Department of Health

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02310	Continued From page 54 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated the nurse must also abide by accepted health care standards, and the use of portable bed rails according to manufacturer's guidelines is one of those accepted standards. Documentation about a resident's bed rails includes, but is not limited to: - purpose and intention of the bed rail; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation and; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Food and Drug Administration's (FDA), A	02310			

Minnesota Department of Health

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02310	Continued From page 55 Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006 indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on	03090			

Minnesota Department of Health

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03090	Continued From page 56 the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 4, 2025, 9:30 a.m., on the front door of the assisted living facility, the surveyor observed the following notice posted on the front door, "This facility could be under surveillance at any time 24/7." The signage lacked the required statutory language for electronic surveillance. On August 5, 2025, at 11:34 a.m., agent/clinical nurse supervisor/licensed assisted living director (A/CNS/LALD)-C stated they thought the posting on the door met the statutory requirement and was unaware of the required language. The licensee's 2.15 Electronic Monitoring policy dated December 1, 2023, indicated licensee would display the following statement, "electronic monitoring devices, including security cameras and audio devices may be present to record persons or activities," No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
LUANN'S PLACE LLC 6660 WEST 175TH AVENUE Eden Prairie, MN 55346 Hennepin County Parcel: Phone:	License: HFID 25323 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F7994251069 Inspection Type: Full - Single Date: 8/4/2025 Time: 10:56:28 AM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 1</u> <u>Total Priority 2 Orders: 1</u> <u>Total Priority 3 Orders: 1</u> <u>Delivery:</u>

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: CURRENT SERVE SAFE BUT NO CURRENT CFPM. CFPM INFO INCLUDED IN EMAIL.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

! 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: EGGS FOUND ABOVE OTHER FOODS IN THE FRIDGE. STORE EGGS AS LOW AS POSSIBLE.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: THERMOMETER FOUND WITHOUT WORKING BATTERY.
Comply By: 8/4/2025 Originally Issued On: 8/4/2025

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

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

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH SIX INCH LEGS, GRANITE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMPERATURES
GROUND BEEF 176

LETTUCE 38

FRUIT 39

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 F7994251069 from 8/4/2025



Establishment Representative

Crystal Elva, REHS, MS, BS
Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version EH Manager; RPT: F7994251069		Food Establishment Inspection Report		Page 1 of 1	
 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164		No. of Risk Factor/Intervention/Violations		1	Date: 8/4/2025
		No. of Repeat Risk Factor/Intervention/Violations			Time: 10:56:28 AM
		Score (optional)			Dur: min
Establishment: LUANN'S PLACE LLC		Address: 6660 WEST 175TH AVENUE		City/State: Eden Prairie, MN	Zip: 55346
License/Permit #: HFID 25323		Permit Holder:		Purpose of Inspection: Full	Est. Type: Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS					
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item					
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					
Mark "X" in appropriate box for COS and/or R					
COS=corrected on-site during inspection R=repeat violation					
Compliance Status				COS	R
Supervision					
1	IN	Person in charge present, demonstrate knowledge and performs duties			
2	IN	Certified Food Protection Manager			
Employee Health					
3	IN	knowledge, responsibilities, and reporting			
4	IN	Proper use of restriction and exclusion			
5	IN	Response to vomiting, diarrheal events			
Good Hygienic Practices					
6	IN	Proper eating, tasting, drinking, tobacco use			
7	IN	No discharge from eyes, nose, and mouth			
Preventing Contamination by Hands					
8	IN	Hands clean and properly washed			
9	IN	No bare hand contact with RTE foods, alternatives			
10	IN	Adequate handwashing sinks supplied and access			
Approved Source					
11	IN	Food obtained from approved source			
12	N/O	Food Received at proper temperature			
13	IN	Food in good condition, safe & unadulterated			
14	N/A	Records available: shellstock tags, parasite dest.			
Protection From Contamination					
15	OUT	Food separated and protected			
16	IN	Food-contact surfaces; cleaned & sanitized			
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food			
GOOD RETAIL PRACTICES					
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.					
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation					
Compliance Status				COS	R
Safe Food and Water					
30	N/A	Pasteurized eggs used where required			
31		Water & ice from approved source			
32	IN	Variance obtained for specialized processing methods			
Food Temperature Control					
33		Proper cooling methods used; adequate equipment for temperature control			
34	N/A	Plant food properly cooked for hot holding			
35	IN	Approved thawing methods used			
36		Thermometers provided & accurate			
Food Identification					
37		Food properly labeled; original container			
Prevention of Food Contamination					
38		Insects, rodents, & animals not present; no unauthorized person			
39		Contamination prevented during food prep, storage, & display			
40		Personal cleanliness			
41		Wiping cloths: properly used & stored			
42		Washing fruits & vegetables			
Person in Charge (signature)					
Inspector (signature)					
Follow-up: Follow-up Date:					
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury					
Proper Use of Utensils					
43		In-use utensils; Properly stored			
44		Utensils, equipment & linens; properly stored, dried, handled			
45		Single-use & single-service articles, properly stored and used			
46		Gloves used properly			
Utensils, Equipment and Vending					
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used			
48	X	Warewashing facilities: installed, maintained, used; test strips			
49		Non-food contact surfaces clean			
Physical Facilities					
50		Hot & cold water available; adequate pressure			
51		Plumbing installed; proper backflow devices			
52		Sewage & waste water properly disposed			
53		Toilet facilities; properly constructed, supplied & cleaned			
54		Garbage & refuse properly disposed; facilities maintained			
55		Physical facilities installed, maintained & clean			
56		Adequate ventilation & lighting; designated areas used			
57		Compliance with MCIAA			
58		Compliance with licensing and plan review			