Electronically Delivered

October 22, 2026

Licensee
United Homes Services
14570 Joppa Avenue South
Savage, MN 55378

RE: Project Number(s) SL36378016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 17, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36378	A. BUILDING: _____ B. WING _____	09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED HOMES SERVICES	14570 JOPPA AVENUE SOUTH SAVAGE, MN 55378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36378016-0 On September 15, 2026, through September 17, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license. 1290: An immediate correction order was issued on September 15, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the ability to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 460		

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0 460	Continued From page 2 On September 15, 2026, at 11:00 a.m., owner/program director (O/PD)-A stated the facility did not have a system in place for residents to request assistance 24 hours a day, seven days a week. O/PD-A stated he was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include	0 485		

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0 485	Continued From page 3 and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract that is used by all residents, included: "[licensee] will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by [license name] staff at the following times: a. Breakfast - 7 AM to 10 AM b. Lunch - After 11:00 AM c. Dinner - After 4:00 PM d. Health snacks are provided 2 times a day e. A staff member is available during meals for assistance with cutting meat or opening containers. f. A menu is posted weekly, and you will be informed in advance of any changes to the menu. Meal substitutions are available. g. Snacks are available throughout the day; you may access food at any time." The licensee's assisted living contract lacked an option for residents to opt out of payment for meals that residents would not want.	0 485		

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0 485	Continued From page 4 On September 17, 2026, at 11:00 a.m., owner/program director (O/PD)-A stated he was unaware meals could not be included in the contracted rate or needed an option to opt out. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced	0 550		

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0 550	Continued From page 5 by: Based on observation, interview, and record review, the licensee failed to have all the required contact information in the posted grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 15, 2026, at 12:15 p.m., the surveyor observed the grievance posting. The posting did not include the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. In addition, the posting did not include the information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On September 15, 2026, at 12:15 p.m., owner/program director (O/PD)-A stated he was unaware the grievance posting was missing required content. The licensee's 2.10 Complaint / Grievance Posting policy dated August 1, 2022, included: - "[licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who	0 550		

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0 550	Continued From page 6 are responsible for handling resident complaint/grievances." - "In addition, the posting will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for the licensee's residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 630		

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0 630	Continued From page 7 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 On September 16, 2026, at 9:57 a.m., the surveyor observed housing manager (HM)-B administering medications to R2 R2 was admitted on November 1, 2020, and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, chronic pain and diabetes. R2's Clinical Update Assessment dated June 25, 2026, did not include R2's risk to abuse others as required. R3 On September 16, 2026, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R3. R3 began receiving assisted living services on February 4, 2022, with diagnoses including traumatic brain injury, depression, and epilepsy. R3's Clinical Update Assessment dated August 13, 2026, did not include R3's risk to abuse others as required. R4 On September 16, 2026, at 10:40 a.m., the surveyor observed owner/program director administering medications to R4.	0 630		

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0 630	Continued From page 8 R4 was admitted on November 1, 2020, and began receiving assisted living services on August 1, 2021. R's diagnoses included pervasive developmental disorder, Asperger's syndrome, attention deficit hyperactivity disorder, depression, and paranoid personality disorder. R4's Clinical Update Assessment dated September 16, 2026, did not include R4's risk to abuse others as required. On September 16, 2026, at 1:19 p.m., clinical nurse supervisor (CNS)-E stated she was unaware the IAPP was required to include the resident's risk to abuse others. The licensee's 6.05 Individual Abuse Prevention Plan policy dated August 1, 2022, included "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 9 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on 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 a facility TB risk assessment completed annually, and failed to complete a TB symptom and TB history screen for one of two employees (unlicensed personnel (ULP)-D. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 10 The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was documented as updated on June 24, 2026; however, the document was dated as completed July 20, 2020, and included Cases of Active TB Disease by County, Minnesota, 2019 rates. On September 16, 2026, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R3. ULP-D's employee record included a TB quantiferon blood test dated December 10, 2025, and a chest x-ray dated December 11, 2025. However, ULP-D's record did not include a TB symptom and TB history screen upon hire, as required. On September 17, 2026, 11:00 a.m., owner/program director (O/PD)-A stated he was unaware the TB facility risk assessment using old rates and was not updated annually except the date at the top of the document. Additionally, O/PD-A stated ULP-D should have had a TB symptom and TB history screen completed upon hire. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment and included "Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history"	0 660		

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0 660	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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UNITED HOMES SERVICES	14570 JOPPA AVENUE SOUTH SAVAGE, MN 55378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 12 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical	0 780		

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0 780	Continued From page 13 environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated Septemeber 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days..	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 15 (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 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 810		

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0 810	Continued From page 16 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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 follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R2). This had the potential to affect all staff, residents, and visitors of the facility. This practice resulted in a level two violation (a	0 830		

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0 830	Continued From page 17 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: Upon arrival at the facility September 16, 2026, at 10:40 a.m., the surveyor observed R4 smoking a cigarette by the back wall of the garage with the garage door open. On September 16, 2026, at 12:15 p.m. during the facility tour with owner/program director (O/PD)-A, the surveyor observed loose tobacco and a lighter on a bench along the back wall of the garage. On September 17, 2026, at 1:37 p.m., O/PD-A and the surveyors observed ashes and a single cigarette butt on the floor of the garage. A strong odor of cigarette smoke was present in the garage. O/PD-A stated only one resident smoked and he smoked in the garage or on the deck. O/PD-A stated he was unaware of Minnesota Clean Indoor Air Act (MCIAA) which prohibited smoking in health care facilities. The Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers,	0 830		

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0 830	Continued From page 18 garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living did not require all residents to waive liability for health, safety, or personal property.	0 970		

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0 970	Continued From page 19 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract that is used by all residents included: - "1.Insurance Liability and Release. The resident shall always maintain his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents." - "Indemnification: [licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the	0 970		

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0 970	Continued From page 20 premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee] It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On September 17, 2026, at 11:00 a.m., owner/program director (O/PD)-A stated he was unaware waivers of liability were prohibited in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted through Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living license for one of nine employees (unlicensed personnel (ULP)-C). This resulted in an immediate correction order on September 15, 2026. 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: ULP-C was hired on May 17, 2021, and provided direct care services to the facility's residents. The licensee's staff schedule indicated ULP-C worked independently on the 9:00 p.m. - 7:00 a.m. shift on September 8, 9, and 10, 2026. The licensee's NETStudy roster indicated ULP-C had a background study completed on June 28, 2021, which was COVID expired on December 31, 2022, and had a background study completed February 7, 2022, which was COVID expired on December 31, 2022. On September 15, 2026, at 2:51 p.m., owner/program director (O/PD)-A stated he was unaware ULP-C's background study was COVID	01290		

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01290	Continued From page 22 expired and that there was not an active BGS with DHS NETStudy 2.0 for ULP-C. The licensee's 4.02 Background Studies policy dated August 1, 2024, included: "[Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [licensee]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received." No further information provided. Time period for correction: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remain at l.	01290		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the	01650		

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01650	Continued From page 23 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 On September 16, 2026, at 9:57 a.m., the surveyor observed housing manager (HM)-B administering medications to R2 R2 was admitted on November 1, 2020, and began receiving assisted living services on	01650		

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01650	Continued From page 24 August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, chronic pain and diabetes. R2's Service Plan Waiver dated August 3, 2026, indicated R2's services included bathing, grooming, incontinence care, behavior management and medication administration. The service plan included: - "The Assisted Living provides services under MN Comprehensive Home care License. The following services checked are available from our staff directly. Other services may be available under contract with other agency providers." R2's Service Plan did not include the following required content: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 25 R3 On September 16, 2026, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R3. R3 was admitted and began receiving assisted living services on February 4, 2022. R3's diagnoses included traumatic brain injury, depression, epilepsy. R3's Service Plan Waiver dated January 1, 2026, indicated R3's services included bathing, grooming, behavior management and medication administration. The service plan included: - "The Assisted Living provides services under MN Comprehensive Home care License. The following services checked are available from our staff directly. Other services may be available under contract with other agency providers." - "If services to be provided are home care services, an individualized initial assessment will be conducted in person by a registered nurse. This initial assessment will be completed within 5 days after initiation of home care services." The Service Plan did not accurately identify initial assessment would be on or before the date of admission. R2's Service Plan failed to include the following required content: - the fees for services; R4 On September 16, 2026, at 10:40 a.m., the surveyor observed owner/program director (O/PD)-A administering medications to R4. R4 was admitted on November 1, 2020, and began receiving assisted living services on August 1, 2021. R's diagnoses included pervasive developmental disorder, Asperger's syndrome,	01650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 26 attention deficit hyperactivity disorder, depression, and paranoid personality disorder. R4's Service Plan Waiver dated May 1, 2026, indicated R4's services included bathing, grooming, behavior management and medication administration. The service plan included: - "The Assisted Living provides services under MN Comprehensive Home care License. The following services checked are available from our staff directly. Other services may be available under contract with other agency providers." - "If services to be provided are home care services, an individualized initial assessment will be conducted in person by a registered nurse. This initial assessment will be completed within 5 days after initiation of home care services." The Service Plan did not accurately identify initial assessment would be on or before the date of admission. R2's Service Plan failed to include the following required content: - the fees for services; On September 16, 2026, at 1:30 p.m., O/PD-A stated he had printed the wrong service plan from the electronic record indicating home care regulations and not the assisted living regulations; therefore, it did not have accurate required content. The licensee's undated, Service Plan Implementation and Revisions policy indicated the service plan would include the following: "The fees for services. The schedule and methods of monitoring reviews or assessments of the client The frequency of sessions of supervision of staff and type of personnel who will supervise staff The extent to which payment may be expected	01650		

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	36378	A. BUILDING: _____ B. WING _____	09/17/2026

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01650	Continued From page 27 from a third-party payer. The charges for services that will not be covered by a third-party payer. The charges the individual may have to pay. A contingency plan for circumstances when services cannot be provided. 5. Plan for contingency action shall include: a. The action to be taken by the home care provider and by the client or client's representative if scheduled services cannot be provided. b. Information and a method for a client or client's representative to contact the home care provider c. Name and contact information of persons the client wishes to have notified in an emergency or if there is a significant change in the client's condition, including identification of person(s) who has authority to sign for the client in an emergency; d. The circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters 6. A medical emergency plan is established which identifies any advance directives the client might have made, as well as code status." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have	01700		

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01700	Continued From page 28 a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of three residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01700		

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01700	Continued From page 29 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 16, 2026, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R3. R3 was admitted and began receiving assisted living services on February 4, 2022. R3's diagnoses included traumatic brain injury, depression, epilepsy. R3's Clinical Update Assessment dated August 13, 2026, did not include include the following: - an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. - interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On September 17, 2026, at 1:19 p.m., clinical nurse supervisor (CNS)-E stated she was unaware the medication assessment did not include all of the required content. The licensee's 7.01 Medication Management-Assessment, Monitoring &	01700		

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01700	Continued From page 30 Reassessment policy dated August 1, 2022, included the following: "3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. "diversion of medication" means misuse, theft, or illegal or improper disposition of medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based	01730		

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01730	Continued From page 31 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730		

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01730	Continued From page 32 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 On September 16, 2026, at 9:57 a.m., the surveyor observed housing manager (HM)-B administering medications to R2 R2 was admitted on November 1, 2020, and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, chronic pain and diabetes. R2's Clinical Update Assessment dated June 25, 2026, indicated R2 received medication set up and reminders; however, it did not identify R2 received medication administration. R2's assessment did not include the following required content: - an accurate statement describing the medication management services that will be provided; and - identification of medication management tasks that may be delegated to unlicensed personnel. R3 On September 16, 2026, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R3. R3 was admitted and began receiving assisted living services on February 4, 2022. R3's	01730		

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01730	Continued From page 33 diagnoses included traumatic brain injury, depression, and epilepsy. R3's Clinical Update Assessment dated August 13, 2026, indicated R3 received medication reminders; however, it did not identify R2 received medication administration. R3's assessment did not include the following required content: (1) an accurate statement describing the medication management services that will be provided; (3) documentation of specific resident instructions relating to the administration of medications; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R4 On September 16, 2026, at 10:40 a.m., the surveyor observed owner/program director (O/PD)-A administering medications to R4. R4 was admitted on November 1, 2020, and began receiving assisted living services on August 1, 2021. R's diagnoses included pervasive developmental disorder, Asperger's syndrome, attention deficit hyperactivity disorder, depression, and paranoid personality disorder.	01730		

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01730	Continued From page 34 R4's Clinical Update Assessment dated September 16, 2026, indicated R4 received medication reminders; however, it did not indicate R2 received medication administration. R4's assessment did not include the following required content: - an accurate statement describing the medication management services that will be provided; and - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On September 16, 2026, at 1:19 p.m., clinical nurse supervisor (CNS)-E stated she was unaware of the missing content on the medication plans. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2022, included the following: "[Licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel	01730		

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01730	Continued From page 35 f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for two of three	01760		

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01760	Continued From page 36 residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 On September 16, 2026, at 9:57 a.m., the surveyor observed housing manager (HM)-B administering medications to R2 R2 was admitted on November 1, 2020, and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, chronic pain and diabetes. R2's service plan dated August 3, 2026, indicated R2's services included bathing, grooming, behavior management and medication administration. R2's medication administration record (MAR) dated September 2026, included: - buspirone 10 milligrams (mg) three times a day as needed administration documented as administered once a day on September 2, 4, 9, 10, 11, 2026, and twice on September 8, 2026; - diclofenac 1% gel apply 2 grams to skin four times a day as needed; - Imodium (loperamide) take 2 soft gels after the	01760		

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01760	Continued From page 37 first loose stool; 1 soft gel after each subsequent loose stool but; no more than 4 soft gels in 24 hours; - loperamide 2 mg take 1 capsule by mouth four times a day as needed for diarrhea; - hydrocodone-acetaminophen take 1 tablet orally every 6 hours as needed for severe pain, documented as administered on September 14, 2026; - ibuprofen may take an additional dose (2-200 mg tablets), in the middle of the night for increased pain; - ibuprofen 600 mg take 1 tablet orally every 6 hours for pain documented as administered September 10, 2026; - ibuprofen 600 mg take 1 tablet by mouth every 8 hours as needed for pain documented as administered September 8, 2026; R2's physician orders signed April 1, 2026, included the following: - buspirone 10 mg take 1 tablet by mouth twice a day, may also take one tablet daily as needed; - diclofenac 1% gel apply 2 grams to skin four times a day; - Imodium 2 mg Cap Take 1 capsule by mouth four times a day as needed for diarrhea; and - ibuprofen 600 mg take one tablet by mouth every eight hours as needed for pain. R2's record review by the surveyor identified the following discrepancies: - Tylenol was not on the MAR, but it was included in prescriber orders and there was a bottle of Tylenol with her other medications; - buspirone order is 1 tablet by mouth twice a day, may also take one tablet daily as needed R2's MAR reads "as needed three times a day." Therefore, R2 received no scheduled doses in September 2026, and received it 'as needed'	01760		

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01760	Continued From page 38 twice on September 8, 2026; - diclofenac order is four times a day. R2's MAR reads 'as needed,' and it had not been administered at all in September 2026; - Imodium is on R2's MAR twice with differing instructions, creating a risk for duplicative administration of the medication; - hydrocodone-acetaminophen is on the MAR and documented as administered, but there is no physician's order; and - ibuprofen 600 mg is on the MAR twice and ibuprofen 2-200 mg tablets at night as needed is on the MAR, this is duplicate therapy which would create a risk of duplicate administration. In addition, there is no order for the ibuprofen 2-200 mg tablets as needed dose. On September 16, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-E stated Tylenol was ordered for R2 and it should have been on the MAR, and she was unsure why it was not. CNS-E further stated R2 did not have a current prescriber order for hydrocodone and did not have that medication; therefore, the staff must have administered acetaminophen and signed it off as hydrocodone-acetaminophen. CNS-E also stated R2 only had 'as needed' buspirone and not a scheduled dose. CNS-E further stated there should not be duplicate therapy as it creates a risk of administering too much medication if administered from multiple orders. R3 On September 16, 2026, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R3. R3 began receiving assisted living services on February 4, 2022, with diagnoses including traumatic brain injury, depression, epilepsy.	01760		

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01760	Continued From page 39 R3's Service Plan Waiver dated January 1, 2026, indicated R2's services included bathing, grooming, behavior management and medication administration. R3's MAR dated September 2026, included the following: - lamotrigine 25 mg tablet. Take two tablets by mouth in the morning with the 200 mg tablets; - sennosides. Take 1 tablet by mouth daily as needed; - bisacodyl suppository. Take 2 tablets by mouth daily as needed for constipation; - doxylamine succinate. Take 1 tablet at night for sleep as needed R3's physician orders dated May 20, 2026, included: - lamotrigine 200 mg, but did not include the 25 mg 2 tabs dose; - sennosides 8.6 mg. Take one tablet by mouth daily; - bisacodyl 5 mg. Take 2 tablets by mouth daily as needed; and - doxylamine 25 mg nightly as needed for sleep. R3's record review by the surveyor identified the following discrepancies: - lamotrigine 25 mg take 2 tablets by mouth in the morning with the 200 mg tablets was not on the physician orders; - sennosides did not have the strength on the MAR and was listed 'as needed', rather than a scheduled dose per the physician order; - bisacodyl listed the wrong route of suppository, and did not include the strength of the medication; - doxylamine did not have the strength listed on the MAR; and	01760		

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01760	Continued From page 40 - Robitussin was on the MAR, but there was no order for it. On September 16, 2026, at 12:53 p.m., clinical nurse supervisor (CNS)-E stated the pharmacy receives physician orders, updates the MAR and notifies her. R3's lamotrigine was increased in the last couple of weeks and she had been notified by the pharmacy, but she did not have any written order for the medication. CNS-E stated the bisacodyl should have had the correct route. CNS-E further stated, "it is difficult getting orders from the physicians and it takes time". The licensee's 7.08 Medication Management-Administration & Setup policy dated August 1, 2022, included the following: "The nursing staff and unlicensed personnel trained to provide medication administration at [licensee] will document any medication administration provided accurately in each resident record." The licensee's 7.12 Medications - Prescribed, Not Prescribed & OTC [over the counter]policy dated August 1, 2022, included the following: "[Licensee] will determine whether the facility shall require a prescription for all medications the provider manages. The facility will inform the resident whether the facility requires a prescription for all over-the-counter and dietary supplements before the facility agrees to manage those medications." "- The RN will review the medication list provided by the resident or prescriber for the resident and determine which medications will need a prescriber's orders. - The nursing staff will follow the policy for medication orders as determined necessary." "Over-the-counter drugs or dietary supplements	01760		

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	36378	A. BUILDING: _____ B. WING _____	09/17/2026

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01760	Continued From page 41 - [Licensee] providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. - The facility must verify that the medications are up to date and stored as appropriate. Although the policy indicated the licensee would have a policy to indicate if over the counter medications required a policy, the policy manual did not include another policy regarding over the counter medications. However, the following policy indicates a written prescriber's order must be obtained for any treatment or medication administration provided to the resident. The licensee's 7.20 Medication & Treatment Orders dated August 1, 2022, included the following: "a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber." "1) The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be	01760		

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01760	Continued From page 42 provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure there were current written or electronically recorded prescriptions for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01820		

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01820	Continued From page 43 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 On September 16, 2026, at 9:57 a.m., the surveyor observed housing manager (HM)-B administering medications to R2 R2 was admitted on November 1, 2020, and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, anxiety, chronic pain and diabetes. R2's service plan dated August 3, 2026, indicated R2's services included bathing, grooming, behavior management and medication administration. R2's medication administration record (MAR) dated September 2026, included: - hydrocodone-acetaminophen. Take 1 tablet orally every 6 hours as needed for severe pain, Documented as administered on September 14, 2026; - ondansetron 4 mg tablet take 1 tablet by mouth every 8 hours as needed for nausea during bowel prep; - Senexon-S 8.6-50 mg. Take 1 tablet by mouth twice a day as needed for constipation; and - Aspercreme 10% Cream topically three times a day to chest wall for pain as needed. R2's physician orders signed April 1, 2026, did not include orders for ondansetron, Senexon-S,	01820		

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01820	Continued From page 44 Aspercreme, or hydrocodone-acetaminophen. On September 16, 2026, at 1:05 p.m., clinical nurse supervisor (CNS)-E stated R2 did not have an active order for hydrocodone and did not have those medications; therefore the staff must have administered acetaminophen and signed it off as hydrocodone-acetaminophen. CNS-E was unaware of the discrepancies between the orders and the MAR for the medications listed above. R3 On September 16, 2026, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-D administering medications to R3. R3 began receiving assisted living services on February 4, 2022, with diagnoses including traumatic brain injury, depression, and epilepsy. R3's Service Plan Waiver dated January 1, 2026, indicated R2's services included bathing, grooming, behavior management and medication administration. R3's MAR dated September 2026, included the following: - lamotrigine 25 mg tablet. Take two tablets by mouth in the morning with the 200 mg tablets; and - Robitussin take 20 milliliters (ml) every 6 hours as needed for cough and chest congestion. R3's physician orders dated May 20, 2026, included: - lamotrigine 200 mg, but it did not include the 25 mg 2 tabs dose; and - there was no order for Robitussin. On September 16, 2026, at 12:53 p.m., clinical	01820		

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01820	Continued From page 45 nurse supervisor (CNS)-E stated the pharmacy receives physician orders, updates the MAR and notifies her. CNS-E stated R3's Robitussin was over the counter. R3 requested and purchased it so CNS-E put them on the MAR. CNS-E stated R3's lamotrigine was increased in the last couple of weeks and she had been notified by the pharmacy, but she did not have a written order for it. CNS-E further stated "it is difficult getting orders from the physicians and it takes time". The licensee's 7.12 Medications - Prescribed, Not Prescribed & OTC [over the counter]policy dated August 1, 2022, included the following: "[Licensee] will determine whether the facility shall require a prescription for all medications the provider manages. The facility will inform the resident whether the facility requires a prescription for all over-the-counter and dietary supplements before the facility agrees to manage those medications." "- The RN will review the medication list provided by the resident or prescriber for the resident and determine which medications will need a prescriber's orders. - The nursing staff will follow the policy for medication orders as determined necessary." "Over-the-counter drugs or dietary supplements - [Licensee] providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. - The facility must verify that the medications are up to date and stored as appropriate. Although the policy indicated the licensee would have a policy to indicate if over the counter medications required a policy, the policy manual did not include another policy regarding over the	01820		

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01820	Continued From page 46 counter medications. However, the following policy indicates a written prescriber's order must be obtained for any treatment or medication administration provided to the resident. The licensee's 7.20 Medication & Treatment Orders dated August 1, 2022, included the following: "a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber." "1) The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office	01820		

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01820	Continued From page 47 until the signature is received." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee ailed to ensure time sensitive medications were labeled with the date opened for one of one resident (R2), failed to ensure medications were maintained bearing the original prescription label for one of one resident (R2), and failed to ensure over the counter medications were stored with the residents name or other identifying information. 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).	01890		

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01890	Continued From page 48 The findings include: On September 16, 2026, at 7:16 a.m., they surveyor and housing manager (HM)-B reviewed the medication cupboard and the following was observed: - R2 - Breo Ellipta inhaler open and in use, was not labeled with an open date and did not have a pharmacy label; - Systane eye drops and Tylenol were in her basket but were not labeled in any way to indicate they were R2's medications. Additionally, there was an unlabeled basket with a bottle of Nyquil and container of Gas Relief medication. On September 16, 2026, at 7:16 a.m., HM-B stated he was unaware Breo Ellipta was a time sensitive medication and he was unsure why it did not have a pharmacy label. HM-B stated he was unaware over the counter medications should be marked with the resident name or some other identifying information to assure use by the resident it is intended for. HM-B further stated he did not know whom the bottle of Nyquil and container of Gas Relief belonged to, and that one of the residents probably picked it up and the staff locked it in the cupboard. On September 16, 2026, at 1:19 p.m., clinical nurse supervisor (CNS)-E stated time sensitive medications should be dated when opened. CNS-E stated she did not know whom the Nyquil and container of Gas Relief belonged to, and she was unaware over the counter medications should be labeled in some way to identify the resident so they are used for the correct resident.	01890		

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01890	Continued From page 49 The licensee's 7 .11 Medication Storage policy dated August 1, 2022, included "medications will be kept securely locked and stored per manufacturer's directions." Breo Elipta's prescribing information dated January 2019, included "BREO ELLIPTA should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard BREO ELLIPTA 6 weeks after opening the foil tray or when the counter reads "0" (after all blisters have been used), whichever comes first." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name,	01910		

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01910	Continued From page 50 strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to to include all required information on the medication disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1's Discharge/Transfer Summary dated April 28, 2026, indicated R1 passed away on April 28, 2026. R1's Medication Disposition dated September 17, 2026, after requested by the surveyor, included the following list of medications: - acetaminophen 500 milligrams (mg) quantity of 1; - albuterol inhaler 90 micrograms (mcg) quantity of 1, there was no prescription number identified; - amlodipine 5 mg quantity of 1; - atorvastatin 20 mg quantity of 1; - Baqsimi One 3 mg nasal spray quantity of 1: - Baqsimi Two 3 mg nasal spray quantity of 1: - buspirone 7.5 mg quantity of 1, there was no	01910		

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01910	Continued From page 51 prescription number identified; - calcitriol 0.25 mcg quantity of 1; - calcium carbonate, no dosage listed, quantity of 1, there was no prescription number identified; - carvedilol 12.5 mg quantity of 1; - cyclobenzaprine 5 mg quantity of 1, there was no prescription number identified; - dexcom sensor quantity of 1; - dicyclomine 10 mg quantity of 1; - docusate 100 mg quantity of 1; - fluoxetine 40 mg quantity of 1; - gabapentin 300 mg quantity of 1; - glucose chewable 4 grams quantity of 1, there was no prescription number identified; - hydralazine 25 mg quantity of 1; - Imodium 2 mg quantity of 1, there was no prescription number identified; - insulin aspart quantity of 1; - ipratroprium/albuterol solution 3 milliliters (ml) quantity of 1; - Lactase 3000 units quantity of 1; - Lantus solostar quantity of 1; - lokelma 10 gram pack quantity of 1; - lurasidone 60 mg quantity of 1; - metoclopram (sic) 10 mg quantity of 1; - metoclopramide 5 mg quantity of 1; - nicotine gum 2 mg quantity of 1, there was no prescription number identified; - novolog insulin quantity of 1; - odansetron 8 mg quantity of 1; - pantoprazole 40 mg quantity of 1; - polyethylene glycol powder 3350 quantity of 1, there was no prescription number identified; - polyethylene glycol powder 3350 listed three additional times with quantity of 1 each; - polyvinyl eye drops quantity of 1; - prednisone 20 mg quantity of 1, there was no prescription number identified; - Compazine 10 mg listed twice with quantity of 1 each;	01910		

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01910	Continued From page 52 - Sevelamar 800 mg quantity of 1, there was no prescription number identified; - Sevelamar 800 mg different instructions with a quantity of 1; - stimulant 8.6-50 mg listed 3 times two with prescription numbers and and one without, each listed as a quantity of 1: - tamsulosin 0.4 mg quantity of 1; - thiamin 100 mg quantity of 1, there was no prescription number identified; - trazadone 50 mg quantity of 1; - vitamin D3 25 mcg quantity of 1; - Zofran 8 mg quantity of 1, there was no prescription number identified. Each medication had the following notation "We disposed of the medication, but we did not complete the process in Residex. There was one more step for us to follow, which was not completed" On September 17, 2026, at 11:24 a.m., owner/program director (O/PD)-A stated the disposition of medications form was initiated at the time of discharge, but they did not complete it. O/PD-A stated the quantity of the medications had not been documented. O/PD-A stated he completed the documentation on September 17, 2026, and put the quantity of 1 and printed it for the surveyor. The licensee's 7.23 Medication Disposal policy dated August 1, 2022, indicated "Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition."	01910		

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01910	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: The licensee failed to ensure medications were administered according to policy and accepted standards of practice for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 16, 2026, at 10:40 a.m., the surveyor observed owner/program director (O/PD)-A administering medications to R4. O/PD-A opened a pre-set pill caddy, counted the	02320		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED HOMES SERVICES	14570 JOPPA AVENUE SOUTH SAVAGE, MN 55378

(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
02320	Continued From page 54 number of pills, and put them into a medication cup. O/PD-A then opened the lock-box and took out a card of methylphenidate 54 milligrams (mg), and punched one into the medication cup. O/PD-A did not compare the medications to the electronic medication administration record (MAR) and administered the medications to R4. O/PD-A then went downstairs to his computer and documented the count for the methylphenidate and the administration of the following medications: - clonidine 1 mg 1/2 tablet - lamotrigine 100 mg 1/2 tablet - venlafaxine 37.5 mg 1 tablet - methylphenidate 54 mg 1 tablet. On September 16, 2026, at 1:19 p.m., clinical nurse supervisor (CNS)-E stated staff should be looking at the MAR and verifying the medications prior to administering them to the residents. The licensee's 7.08 Medication Management-Administration & Setup policy dated August 1, 2022, included "5. For active assistance with medications from the dosage box system, the ULP will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, dosage, date, and time administered. It will also include the purpose of the medication and any special instructions if applicable." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

UNITED HOMES SERVICES
14570 JOPPA AVENUE SOUTH
Savage, MN 55378
Scott County
Parcel:

Phone:

License Info

License: HFID 36378

Risk:
License:
Expires on:
CFPM: Ali Iman Mohamed
CFPM #: CFPM-20072; Exp: 1/19/2028

Inspection Info

Report Number: F1047261258
Inspection Type: Full - Single
Date: 9/15/2026 Time: 10:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: UNABLE TO LOCATE EMPLOYEE ILLNESS LOG AT TIME OF INSPECTION- CORRECTED ON SITE. FACILITY PROVIDED COPY OF ILLNESS LOG VIA EMAIL
Comply By: 9/15/2026 Originally Issued On: 9/15/2026

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator S. Haag.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 F1047261258 from 9/15/2026

Ali Mohamed
Operator

Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

UNITED HOMES SERVICES
Savage
County/Group: Scott County

Inspection Info

Report Number: F1047261258
Inspection Type: Full
Date: 9/15/2026
Time: 10:00 am

Food Temperature: Product/Item/Unit: Brats**; Temperature Process:** Cold-Holding
Location: Refrigerator Drawer at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Butter**; Temperature Process:** Cold-Holding
Location: Kitchen Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

UNITED HOMES SERVICES
Savage
County/Group: Scott County

Inspection Info

Report Number: F1047261258
Inspection Type: Full
Date: 9/15/2026
Time: 10:00 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36378016	**Date:** 9/15/2026
Facility Name: United Homes Services	
Facility Address: 14750 Joppa Ave S., Savage, MN 55378	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Improperly discarded cigarette butts were located on the floor of the garage of the facility. The cigarette butts were thrown on the floor near combustible materials and were not contained within approved containers. All smoking materials including cigarettes should be properly disposed of in approved receptacles. The cigarette butts on the floor in the garage should be picked up and disposed of properly, and the garage floor should be maintained free of loose smoking materials.

3. A working space of not less than 30 inches in width, 36 inches in depth and 78 inches in height shall be provided in front of electrical service equipment. Where the equipment is wider than 30 inches, the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

   Comments: Trash cans were stored in front of the electrical panel in the garage which limited access to the fuses. The area immediately in front of the electrical panel should be maintained free of obstruction so that it may be readily accessed.

4. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: A battery powered smoke alarm was installed over hardwired smoke alarm mounting hardware in the basement of the facility. Hardwired smoke alarms must be replaced with alarms of the same power supply, with the hardwired connection maintained. The hardwired smoke alarm was not replaced with alarms with the same power supply and must be replaced with a hardwired smoke alarm. The hardwired connections of smoke alarms should be restored and smoke alarms maintained in a state of good repair and operability.

☒ **TAG IDENTIFICATION: 0780**

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

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1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: The smoke alarm installed in resident room 2 did not properly interconnect with the other smoke alarms provided in the facility. Smoke alarms were tested during the survey by facility staff. During the test, the smoke alarm in resident room 2 failed to interconnect and did not sound when other smoke alarms were actuated. All other smoke alarms were properly interconnected. Smoke alarms should be maintained as interconnected such that the activation of one alarm causes all other smoke alarms to sound.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments:

   The ventilation fan cover in the upper-level bathroom was covered in a significant amount of dust and the fan's motor made a grinding noise when activated. The accumulated dust should be cleaned from the bathroom fan, and the assembly should be maintained in a clean condition and in proper working order.

The caulking around the base of the toilet in the upper-level bathroom was significantly deteriorated and discolored. The decayed caulking left the area unsealed and created a gap around the toilet that allowed the penetration of water into the subfloor. The seal should be repaired and maintained as watertight. The toilet and surrounding area should be brought to and maintained in a clean and sanitary state of good repair.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The licensee failed to provide site-specific staff actions for evacuation during a fire or similar emergency. Facility staff provided the surveyor with general information about fire safety and general policies but did not provide site-specific employee actions for evacuation. The facility should have a readily accessible FSEP that should include site-specific staff actions for evacuation.

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

   Comments: The licensee failed to provide resident actions for evacuation during a fire or similar emergency. No resident actions were provided to the surveyor and staff indicated that such a policy had not been created. The FSEP should include site-specific resident actions for evacuation.

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

   Comments: The licensee failed to provide record of resident training on fire safety and evacuation policies. No record of resident trainings on the FSEP was provided to the surveyor. Trainings should be provided for residents at least once per year.

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

Comments: The licensee failed to provide adequate record of evacuation drills. Evacuation drills should occur at least twice per shift per year and at least once every other month.